

**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, 2023

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

(State or other jurisdiction of incorporation or organization)

42-1406317

(I.R.S. Employer Identification Number)

7700 Forsyth Boulevard

St. Louis,

(Address of principal executive offices)

Missouri

63105

(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	<input checked="" type="checkbox"/>	Accelerated filer	<input type="checkbox"/>
Non-accelerated filer	<input type="checkbox"/>	Smaller reporting company	<input type="checkbox"/>
		Emerging growth company	<input type="checkbox"/>

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, 2023, was \$36.8 billion.

As of February 16, 2024, the registrant had 534,863 thousand shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2024 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," "intend," "seek," "target," "goal," "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 future operating or financial performance, market opportunity, competition, 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, levels of activity, performance or achievements to be materially different from any future results, levels of activity, 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 including but not limited to any impacts resulting from Medicaid redeterminations;
 - 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 can impact revenue and future growth;
 - our ability to accurately predict and effectively manage health benefits and other operating expenses and reserves, including fluctuations in medical utilization rates;
 - competition, including for providers, broker distribution networks, contract procurements and organic growth;
 - our ability to adequately anticipate demand and provide for operational resources to maintain service level requirements;
 - 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 parties;
 - 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;
 - rate cuts or other payment reductions or delays by governmental payors and other risks and uncertainties affecting our government businesses;
 - changes in healthcare practices, new technologies, and advances in medicine;
 - increased healthcare costs;
 - inflation and interest rates;
 - the effect of social, economic, and political conditions and geopolitical events, including as a result of changes in U.S. presidential administrations or Congress;
 - changes in market conditions;
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- 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;
- 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;
- changes in provider, broker, vendor, state, federal, foreign, and other contracts and delays in the timing of regulatory approval of contracts, including due to protests;
- 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 made by states with regard to past practices, including at Centene Pharmacy Services (formerly Envolve Pharmacy Solutions, Inc. (Envolve)), as our pharmacy benefits manager (PBM) subsidiary, within the reserve estimate we previously reported and on other acceptable terms, or at all, or whether additional claims, reviews or investigations will be brought by states, the federal government or shareholder litigants, or government investigations;
- challenges to our contract awards;
- cyber-attacks or other data security incidents;
- 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.

- Failure to accurately estimate and price our medical expenses or effectively manage our medical costs or related administrative costs could 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;
 - Any failure to adequately price or anticipate demand for products offered, anticipate changes to the competitive landscape or any reduction in products offered for Medicare Advantage and in the Health Insurance Marketplace may 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 could have a material adverse effect on 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;
 - 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;
 - 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 our 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 are unable to maintain relationships with our provider networks, our profitability may be materially adversely affected;
 - 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 parties 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;
 - Reductions in funding, 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 or judicial challenges to the ACA could materially and adversely affect our business;
 - 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 pharmacy services face regulatory and other competitive 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;
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- If we fail to comply with applicable data privacy and security laws, regulations, rules, standards and contractual obligations, including with respect to third-party service providers 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;
 - 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;
 - Previous or future acquisitions may not perform as expected and we may not realize the financial results expected from acquisitions or divestitures, which may cause the market price of our common stock to decline;
 - We may be unable to successfully integrate our existing business with acquired businesses and realize the anticipated benefits of such acquisitions; and
 - Our business and results of operations may be materially adversely affected if we fail to manage and complete divestitures.
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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,		
	2023	2022	2021
GAAP net earnings attributable to Centene	\$ 2,702	\$ 1,202	\$ 1,347
Amortization of acquired intangible assets	718	817	770
Acquisition and divestiture related expenses	70	213	185
Other adjustments ⁽¹⁾	464	1,540	1,275
Income tax effects of adjustments ⁽²⁾	(308)	(410)	(537)
Adjusted net earnings	\$ 3,646	\$ 3,362	\$ 3,040
GAAP diluted earnings per share (EPS) attributable to Centene	\$ 4.95	\$ 2.07	\$ 2.28
Amortization of acquired intangible assets	1.32	1.40	1.31
Acquisition and divestiture related expenses	0.13	0.36	0.31
Other adjustments ⁽¹⁾	0.85	2.65	2.16
Income tax effects of adjustments ⁽²⁾	(0.57)	(0.70)	(0.91)
Adjusted diluted EPS	\$ 6.68	\$ 5.78	\$ 5.15

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

2023:

- (a) Circle Health Group (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).

2022:

(b) 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 PBM legal settlement of \$6 million, or \$0.01 per share (\$0.00 after-tax).

2021:

(c) 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, 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.

	Year Ended December 31,		
	2023	2022	2021
GAAP selling, general and administrative expenses	\$ 12,563	\$ 11,589	\$ 9,601
Less:			
Acquisition and divestiture related expenses	69	202	157
Restructuring costs	79	—	54
Costs related to the PBM legal settlement	—	6	14
Real estate optimization	8	15	—
Adjusted selling, general and administrative expenses	<u>\$ 12,407</u>	<u>\$ 11,366</u>	<u>\$ 9,376</u>

Note: Beginning in 2022, we have included a separate line item for depreciation expense in the Consolidated Statements of Operations, which was previously included in selling, general and administrative (SG&A) expenses. Prior period SG&A expenses have been conformed to the current presentation.

PART I

Item 1. *Business*

OVERVIEW

Our mission is to transform the health of the communities we serve, one person at a time. Centene is a leading provider of government-sponsored healthcare. We provide access to quality healthcare for nearly 1 in 15 individuals nationwide through government-sponsored programs, including Medicaid, Medicare and the Health Insurance Marketplace. Our focus is on improving health and health care for low-income, complex populations.

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. Our uniquely local approach – with local brands and local teams who live in, care about and directly influence the communities they serve – is a key differentiator in our ability to provide access to quality care to our members. Centene treats the whole person, an approach that is delivered locally but backed by the scale of Centene's expertise, data and resources. Through this approach and our commitment to sustainable partnerships, we work with local community organizations to realize our mission of transforming the health of the communities we serve, one person at a time.

We are focused on making strategic decisions and investments to create additional value in the short-term and to seek opportunities that position the organization for long-term strength, profitability, growth and innovation. In addition to creating shareholder value, we are modernizing and improving how we work in order to propel our organization to new levels of success and elevate the member and provider experiences.

During 2023, 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, Medicare Supplement, Dual Eligible Special Needs Plans (D-SNPs) and Medicare Prescription Drug Plans (PDP), also known as Medicare Part D.
- **Commercial** - includes the Health Insurance Marketplace product along with individual, small group and large group commercial health insurance products.
- **Other** - includes our pharmacy operations, Envolve Benefit Options' vision and dental services, clinical healthcare, behavioral health, international operations and corporate management companies, among others. Our international businesses, Operose Health Group (Operose Health) and Circle Health Group (Circle Health), were divested in December 2023 and January 2024, respectively.

For the year ended December 31, 2023, our Medicaid, Medicare, Commercial and Other segments accounted for 66%, 14%, 16% and 4%, respectively, of our total external revenues. Our membership totaled 27.5 million as of December 31, 2023. For the year ended December 31, 2023, our total revenues and net earnings attributable to Centene were \$154.0 billion and \$2.7 billion, respectively, and our total cash flow from operations was \$8.1 billion.

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 Temporary Assistance for Needy Families (TANF) program covers low-income families with children.
- Medicaid Expansion covers all individuals under age 65 with incomes up to 138% of the federal poverty level, subject to each states' election. The federal government pays 90% of the costs for Medicaid Expansion coverage for these beneficiaries.
- The Aged, Blind or Disabled (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.
- The Children's Health Insurance Program (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.
- Long-Term Services and Supports (LTSS) is a Medicaid product that covers Institutional/Residential Care (Nursing and Intermediate Care Facilities) and Home and Community Based Services (HCBS) for beneficiaries requiring assistance with their activities of daily living. The largest groups receiving LTSS, by spending, are older individuals and individuals with physical disabilities, followed by individuals with intellectual and developmental disabilities, those with serious mental illness and/or serious emotional disturbance and other populations. States are increasingly turning to managed care as a solution to provide coordinated, holistic care to their LTSS beneficiaries.
- The majority of children in foster care qualify for Medicaid. The federal government has enacted legislation establishing requirements for state child welfare agencies related to the health and well-being of children in foster care, including the provision of grants and technical assistance to enable states to meet these needs and make explicit connections with Medicaid. In addition, under the ACA, former foster care children are eligible for Medicaid until the age of 26, provided that they turned 18 while in foster care and were enrolled in Medicaid at that time.
- 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 the CMS, there were approximately 12.4 million dual-eligible enrollees in 2022. 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 issues. We serve dual-eligibles primarily through our ABD, LTSS, Medicare-Medicaid Plan (MMP) and Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) lines of business.

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. Rather, they have sought 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 lower costs, the majority of states have mandated that their Medicaid recipients enroll in managed care plans and are considering moving to a mandated managed care approach for additional populations and products. CMS estimates the total Medicaid program will grow from \$787 billion in 2022 to \$1.2 trillion by 2031. Medicaid spending is estimated to have increased by 4% in 2023 and is projected to increase at an average annual rate of 5% between 2022 and 2031. Based on these trends, 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 more than 14 million Medicaid recipients in 30 states as of December 31, 2023. Our Medicaid contracts with each of the states of New York, Florida and California accounted for approximately 10% or more of our consolidated Medicaid premium revenues individually in the year ended December 31, 2023.

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.

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. 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.

The Congressional Budget Office estimates the total Medicare market will grow from \$973 billion in 2022 to \$2.1 trillion by 2033. Medicare spending is estimated to have increased 8% in fiscal 2023 and is projected to increase at an average annual rate of 7% between 2022 and 2033. Over 40% of Medicare spend in 2023 was in Medicare fee-for-service, representing a notable market opportunity to increase penetration of the Medicare Advantage products.

As of December 31, 2023, we served 1.3 million Medicare Advantage members across 36 states, primarily under the brand name Wellcare, with the highest concentration of lower-income, complex members compared to our competitors. Revenues from CMS are significant to the segment.

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 and by providing 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, including 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 on the first Monday 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.

We offer stand-alone PDPs in 50 states and the District of Columbia, serving 4.6 million members as of December 31, 2023.

Commercial

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. Access to the federally-facilitated Marketplace is limited to U.S. citizens and legal immigrants. 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 Inflation Reduction Act.

We are the largest Marketplace carrier, serving 3.9 million members across 28 states as of December 31, 2023, under the brand name Ambetter Health. Revenues from CMS are significant to the segment.

We also offer commercial health insurance products to individuals through large and small employer groups. We offer plans with differing benefit designs and varying levels of co-payments at different premium rates. These plans are offered generally through contracts with participating network physicians, hospitals and other providers. Coverage typically is subject to copays and can 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.

Other

Our Other segment includes:

- *Specialty Pharmacy.* AcariaHealth offers comprehensive specialized pharmacy benefit and care management services for complex diseases by enhancing the patient care offering through collaboration with providers and the capture of relevant data to measure patient outcomes.
- *Behavioral Health.* Magellan Health, Inc. (Magellan) 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.
- *Vision and Dental Services.* Envolve Benefit Options coordinates benefits beyond traditional medical benefits to offer fully integrated vision and dental health services. Our vision benefit program administers routine and medical 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.

- *Federal Services.* Health Net Federal Services has a Managed Support Contract in the West Region for the Department of Defense (DoD) TRICARE program. We provide administrative services to Military Health System eligible beneficiaries, which includes eligible active duty service members and their families, retired service members and their families, survivors of retired service members and qualified former spouses. Our current contract for health care delivery services concludes at the end of 2024.
- *Corporate Management Company.* Each of our health plans contracts with our wholly-owned corporate management company to provide certain functions required to manage the health plan including, but not limited to, salaries and wages for personnel, rent, utilities, population health management, provider contracting, compliance, member services, claims processing, information technology, cash management, finance and accounting and other services.
- *International Operations.* Circle Health is one of the U.K.'s largest independent hospital operators. Operose Health represents one of the largest provider networks in the U.K. and delivers medical and community-based services in the primary care sector of the National Health Service, which is the publicly funded, national healthcare system for England. Our international businesses, Operose Health and Circle Health, were divested in December 2023 and January 2024, respectively.

OUR COMPETITIVE STRENGTHS

Our approach is based on the following key competitive strengths:

- *Power of Incumbency.* Centene was founded as a Medicaid company and our business is built on Medicaid as the foundation, anchored around long-lasting, trusted relationships. The years we have spent forging new paths, developing innovative solutions and addressing the evolving needs of our members has earned Centene an important seat at the table and a powerful voice to shape the conversation at the state and federal level. We've deliberately increased our market density by expanding our reach to products beyond Medicaid and as a result, we are the largest Medicaid health insurer and Marketplace carrier in the country.
- *Local Where It Matters.* 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 social 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, we're 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 strategy and a discipline: finding, measuring and maintaining the best partners over time. Instead of owning providers, we are identifying the best providers for our members, investing in data and engagement models that will support them in delivering health outcomes. For example, we are steadily increasing the number of our members in value-based arrangements in all three lines of business, which lead to a better experience for our providers and higher quality care for our members.

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 reducing and managing costs, 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. This experience has led to sole source foster care contracts in Florida, Illinois, Missouri, Oklahoma, Texas and Washington.
- *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 Medicare Star ratings in the future.
- *Community-specific healthcare programs and a focus on addressing health equity.* Our expertise in government-sponsored programs has helped us establish and maintain strong relationships with community-based organizations, 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 health equity.
- *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, cost optimization and the attraction and retention of new members. Primary care physicians include family and general practitioners, pediatricians, internal medicine physicians, obstetricians and gynecologists. 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 contract with providers on a negotiated fee arrangement for physical therapy, home healthcare, diagnostic laboratory tests, x-ray examinations, transportation, 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 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, this 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 includes 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 in cost and quality measures. We are committed to value-based contracting, up and downside risk, assigning members to the highest quality providers and capitation. This is done in complete partnership with our providers to increase quality outcomes and overall member satisfaction. We anticipate our membership in up 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. We meet with the providers to review their performance issues and recommend strategies for improvements in their patient panel outcomes. 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 a secure, user-friendly web-based provider portal. This is provided through our suite of technology platforms.

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 recent investments in key initiatives involving people, processes, technology and partner management.

Through these initiatives, we have:

- centralized the oversight of core quality processes and programs, including the implementation of real-time operational dashboards to track numerous quality performance metrics;
- invested in new technology to enhance our access to clinical data on gaps in care, committed to integrating our numerous quality platforms into a single unified workflow and developed advanced analytics to more efficiently and effectively target our member engagement efforts for maximal impact on access, quality and member satisfaction;
- increased focus on member engagement, including tripling the capacity of our member outreach services to encourage active participation with their primary care physicians and other members of their care team and overhauling our onboarding process to focus on quality from the very first member touchpoint for Medicare, Medicaid and the Marketplace; and
- prioritized strengthening relationships with providers to improve access and quality of care for our members; an essential strategy on this front is increasing our value-based provider engagements as those enhanced partnerships have proven to drive higher quality care. We also continue to promote local participation in physician quality improvement committees chaired by local physician leaders, which ensures clinical oversight and is critical to the success of clinical quality improvement programs.

We believe these initiatives will improve members' overall health and healthcare experience and help us achieve stronger Medicare Star ratings.

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 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 and Health Equity Accreditation 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 only one measure of our ability to provide access to quality care for our members. 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 and detection of fraud, waste and abuse and the resolution of 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.

Three standards by which corporate compliance programs in the healthcare industry are measured are the Federal Organizational Sentencing Guidelines, the CMS Chapter Guidance and the Compliance Program Guidance series issued by the Department of Health and Human Services' Office of the Inspector General. Our program contains each of the seven elements suggested by these authorities.

These key components 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 program is to build a culture of integrity, ethics and compliance, which is assessed periodically to measure engagement and effectiveness. Our Enterprise 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. The Company's 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 sustainability initiatives throughout the organization are driven by a cross-functional network of executive representatives.

Annually, we issue a sustainability report to communicate the value of our efforts, a Task Force on Climate-related Financial Disclosures (TCFD) Index report outlining our governance structure, strategy, risks, opportunities and metrics and target-setting related to managing climate change, and a Sustainability Accounting Standards Board (SASB) Index report aligned with the SASB Managed Care standard, providing sustainability disclosures to our stakeholders. The Framework enables us to communicate impact and progress on sustainability matters important to our stakeholders and aligned with our business strategy and long-term plans. Sustainability financial reporting disclosures are overseen by the Board of Directors' Audit and Compliance Committee. Our sustainability initiatives and commitments enable us to build healthier communities, empower health, foster a healthy environment and drive business accountability. Interested parties can find our sustainability-related reports within the Investors section of our website, the URL of which is <https://investors.centene.com/esg>. *Please note: Nothing on our website, including our sustainability reports or sections thereof, shall be deemed incorporated by reference into this Annual Report.*

COMPETITION

We operate in a highly competitive environment in an industry subject to ongoing significant changes, including business consolidations, new strategic alliances, market pressures and regulatory and legislative reform both at the federal and state level. This includes, but is not limited to, the federal and state healthcare reform legislation described under the heading "Regulation." In addition, changes to the political environment may drive additional changes to the competitive landscape.

We compete with other MCOs, specialty companies and other non-traditional competitors to acquire and retain state, county, federal and commercial contracts. Before granting a contract, state and federal government agencies consider many competitive factors. These factors include quality of care, financial condition, stability and resources, local investments and offerings and established or scalable infrastructure with a demonstrated ability to deliver services and establish comprehensive provider networks.

We also compete to enroll new members and retain existing members. People who wish to enroll in a managed healthcare plan or to change healthcare plans typically choose a plan based on the quality of care and services offered, ease of access to services, a specific provider being part of the network and the availability of supplemental benefits. We believe that the principal competitive features affecting our ability to retain and increase membership include the range and prices of benefit plans offered, size and quality of provider network, quality of service, quality ratings, responsiveness to customer demands, financial stability, comprehensiveness of coverage, diversity of product offerings, market presence and reputation.

We also compete with other MCOs in establishing provider networks. When contracting with various health plans, we believe that providers consider existing and potential member volume, reimbursement rates, provider experience, value-based payment programs, speed of reimbursement and administrative service capabilities. See "Risk Factors - *Competition may limit our ability to increase penetration of the markets that we serve.*"

The relative importance of each of the aforementioned competitive factors and the identity of our key competitors varies by market, including by geography and by product. We believe that we compete effectively against other healthcare industry participants.

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, proper billing, complaint procedures, provider network and procedures for covering emergency medical conditions. For example, under both state MCO statutes and insurance laws, our health plan subsidiaries, as well as our applicable specialty companies, 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. Medicaid 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 or judicial challenges to the ACA 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. In addition, as a result of our international operations, we are subject to the U.S. Foreign Corrupt Practices Act (FCPA) and similar worldwide anti-corruption laws, including the U.K. Bribery Act of 2010, which generally prohibit companies and their intermediaries from making improper payments to non-U.S. officials for the purpose of obtaining or retaining business. 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 which are provided under 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, as well as other CMS regulations and the quality of care we provide to Medicare beneficiaries under these contracts.

As of December 31, 2023, we operated in 28 states under federally-facilitated Marketplace contracts with CMS and state-based exchanges. We 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 government contracts include government-sponsored managed care and administrative services contracts through the TRICARE program and certain other healthcare-related government contracts.

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 procurement 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 following up on 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. While we have both prospective and retrospective processes to identify abusive patterns and fraudulent billing, we continue to increase our capabilities to proactively detect inappropriate billing prior to payment.

Privacy Regulations

We are subject to various international, 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), the General Data Protection Regulation (GDPR) 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 the pace of change and complexity in the broader environment accelerates, we continue our strong investment in creating a mission-driven culture. We intentionally attract, develop and retain top talent who have diverse voices and experiences, passion and vision well-positioned to help us transform the health of communities we serve. As of December 31, 2023, we had approximately 67,700 team members. Circle Health, divested in January 2024, had approximately 8,300 team members at December 31, 2023.

Workforce Culture and Benefits

We maintain the health and well-being of our team members as one of the main driving factors of business decisions. 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.

We have adopted a modern work environment. The majority of our team members leverage remote and hybrid work arrangements and are empowered to do their best work in the way they work best. We are intentional in our efforts to foster a collaborative, inclusive and engaging work environment, including monthly forums for people leaders, robust weekly communications for all team members, virtual all-employee meetings and employee programming to help amplify multiple perspectives and lived experiences.

Our compensation and benefits programs are market competitive and designed to attract and retain talent. Our overall compensation philosophy is to pay for performance by linking the achievement of both Company and individual goals to total compensation. In addition to traditional medical and pharmacy benefits, we also offer wellness programs, employee assistance program, tuition reimbursement/educational assistance, adoption reimbursement, 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 the communities in which we serve.

We leverage a continuous listening approach with our team members, actively soliciting their perspective on our culture and their experiences and engagement. This feedback allows us to attract and retain our mission-driven workforce.

Diversity, Equity and Inclusion

We believe that a diverse workforce and an equitable, inclusive environment is critical to achieving our mission and advancing high performing teams. Our commitment to diversity, equity and inclusion is foundational to our strategy. Our talent advisors and hiring leaders leverage a diverse pipeline resulting in a workforce with team members from a wide range of lived experiences.

To promote engagement, inclusiveness and strong connections between team members across the organization, we have a wide range of Employee Inclusion Groups (EIGs). These voluntary, employee-led groups provide professional connections and leadership opportunities for all team members including military veterans and their families, individuals with disabilities and caregivers of individuals with disabilities, women, LGBTQIA+, multicultural team members and intergenerational team members. Today, there are over 23,000 team members participating in our EIGs.

Talent Development

Through our robust talent infrastructure, we continue working to deepen and prepare our diverse talent bench and workforce, which is instrumental to executing our long-term business strategy. 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, we have designed learning and development at scale, using new digital tools, real-time virtual learnings and customized leadership development programs, accessible to all team members, 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 through our People Plans, the integrated human capital component of our annual operating plans.

INFORMATION ABOUT OUR EXECUTIVE OFFICERS

The following table sets forth information regarding our executive officers, including their ages, at February 16, 2024:

Name	Age	Position
Sarah M. London	43	Chief Executive Officer
Andrew L. Asher	55	Executive Vice President, Chief Financial Officer
Katie N. Casso	42	Senior Vice President, Corporate Controller and Chief Accounting Officer
Kenneth J. Fasola	64	President
Christopher A. Koster	59	Executive Vice President, Secretary and General Counsel
Susan R. Smith	48	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, Corporate Controller and Chief Accounting Officer since April 2021. From January 2016 to March 2021, she served as Vice President, Assistant Controller.

Kenneth J. Fasola. Mr. Fasola has served as our President since December 2022. From January 2022 to December 2022, he served as Executive Vice President, Health Care Enterprises. Mr. Fasola joined Centene upon the acquisition of Magellan Health in January 2022, where he served as the Chief Executive Officer since November 2019. From April 2019 to November 2019, he served as Chief Growth Officer of Ancillary and Individual Health Services at United Healthcare. From October 2010 to April 2019, he served as Chairman, President and Chief Executive Officer of HealthMarkets, Inc.

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.

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 accurately estimate and price our medical expenses or effectively manage our medical costs or related administrative costs 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. 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, 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. 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, the level of utilization of healthcare services, out-of-network utilization and pricing, medical claim submission patterns, 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 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 behavior could continue to be influenced by the uncertainty surrounding the ACA, including potential further legal challenges to the ACA or potential changes in premium subsidies.

Our medical expenses include claims reported but not paid, estimates for claims incurred but not reported (IBNR), 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. For example, we have established a premium deficiency reserve in connection with the 2024 Medicare Advantage business as of December 31, 2023. 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. 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. The addition of new categories of eligible individuals, as well as evolving Health Insurance Marketplace plans, 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 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.

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 October 2023, approximately 87% of membership was associated with contracts rated 3.0 stars or better. Our quality improvement goal is to move 85% of our members into contracts with 3.5 stars or better for rating year 2026 (anticipated to be published in October 2025), which may not be achieved. 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.

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. Our quality bonus and rebates may continue to be negatively impacted and our Medicare Advantage and PDP contracts may be terminated by CMS. For example, two of our Medicare Advantage contracts have received notice of termination for plan year 2025 and other Medicare Advantage contracts have received Star scores of below 3.0 stars for two consecutive years and accordingly could be terminated for plan year 2026 if their Star scores do not improve. The attractiveness of our Medicare Advantage plans may be reduced if we are unable to maintain or improve these ratings, or if there are changes to the ratings system that make achieving and maintaining ratings of 3.0 stars or higher more difficult.

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 2024, CMS estimates that the risk model revisions together with the impact of normalization will reduce payments by 2.16%. As a result of these changes, and our 2024 Medicare Advantage bid design and membership projections, we have established a premium deficiency reserve in connection with the 2024 Medicare Advantage business as of December 31, 2023. In addition, CMS' new risk model may not account for the full severity of several chronic conditions, which could also disproportionately affect the dual eligible population who are more medically complex and face 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, proposed CMS regulations may require beneficiaries dually enrolled in Medicare and Medicaid to receive integrated care through Medicare Advantage D-SNPs, which may restrict our product offerings in some geographic service areas.

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, 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 are 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. We anticipate that CMS will continue to conduct audits of our Medicare contracts and contract years on an on-going basis. 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.

Any failure to adequately price or anticipate demand for products offered, anticipate changes to the competitive landscape or any reduction in products offered for Medicare Advantage 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 predicted the health needs of our members, including due to individuals exiting the market causing the morbidity of the risk pool to rise without a proportionate change to risk adjustment. 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 participants. Further, changes in the competitive market for both Health Insurance Marketplace and the Medicare Advantage products over time, changes to member eligibility in the program design 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, enrollment levels, adverse selection, out-of-network costs 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 Advantage products.

In addition, we may be unable to accurately predict demand for both our Health Insurance Marketplace and Medicare Advantage products, as demand depends on factors outside of our control such as the competitiveness of our bids, the broker distribution channels 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.

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, as part of the normal course of business, several of our Medicaid contracts are up for reprocurement in 2024 (for contracts largely commencing in 2025), including but not limited to Florida, Georgia, a portion of our business in Texas and Michigan. Competitors may be more aggressive in the descriptions of their capabilities and the assumptions utilized in their bids. 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. For example, as a result of a Medicaid reprocurement process in California, in January 2024 our subsidiary, Health Net of California, began subcontracting a portion of its Medicaid membership in Los Angeles, which reduced our membership, compared to December 2023.

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. For example, several states have made claims related to services previously provided by Envolve, which historically provided PBM and specialty pharmacy services, including among other things, (i) claims seeking payment for services already reimbursed, (ii) claims alleging the failure to accurately disclose the true cost of the PBM services and (iii) claims alleging inflation of dispensing fees for prescription drugs. For additional information, see Note 17. *Contingencies* to the consolidated financial statements included in Part II of this Annual Report on Form 10-K. Additional claims, reviews or investigations may still be brought by other states, the federal government or shareholder litigants, and there is no guarantee we will have the ability to settle such claims with other states within the reserve estimate we have recorded and on other acceptable terms, or at all. 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 parties, 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 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 2024 PDP bids resulted in 30 of the 34 CMS regions in which we were below the benchmarks and 4 regions in which we were within the de minimis range, largely consistent with our 2023 PDP bids. As of January 1, 2024, we experienced an increase of 1.7 million PDP members compared to December 2023, due to our 2024 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.

The Inflation Reduction Act (IRA) is expected to substantially increase PDP's risk exposure in 2025. Under IRA, PDP plan costs will increase 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 will fall into the catastrophic phase). In the meantime, Part D risk sharing program thresholds would be applied to the increased Part D plan costs, so the plan cost at risk will be much greater before any risk sharing kicks in. These changes may lead to heightened underwriting risks and increased market volatility and uncertainty for 2025 bids, which could materially reduce our revenue and profit.

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.

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 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.

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, several of our Medicaid contracts are up for reprocurement in 2024 (for contracts largely commencing in 2025), including but not limited to Florida, Georgia, a portion of our business in Texas and Michigan. 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, as a result of Medicaid reprocurement process in California, in January 2024 our subsidiary, Health Net of California, began subcontracting a portion of its Medicaid membership in Los Angeles, which reduced our membership compared to December 2023. 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; and
- new market entrants, including those not traditionally in the health service industry.

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 our 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 parties. We contract with various vendors to perform certain functions and services, including for PBM, medical management and other member-related services. Our arrangements with these third parties 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 parties' 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 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 are unable to maintain relationships with our provider networks, 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. For example, our wholly owned subsidiary, Health Net Life Insurance Company (HNL), is and may continue to be subject to such disputes with respect to HNL's payment levels in connection with the processing of out-of-network provider reimbursement claims for the provision of certain substance abuse related services. In the event HNL receives an adverse finding in any related legal proceeding or from a regulator or is otherwise required to reimburse providers for these claims at rates that are higher than expected or for claims HNL otherwise believes are unallowable, our financial condition and results of operations may be materially adversely affected. 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.

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 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, 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. We may from time to time obtain significant portions of our systems-related or other services or facilities from independent third parties, which may make our operations vulnerable if such third parties 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 parties 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 parties, 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 those of third parties 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 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 service providers. 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 service providers, 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 had data breaches 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 2021, we learned that Accellion, a third-party data transfer provider with whom we contract, had a system vulnerability that resulted in unauthorized access to certain sensitive data of our customers, including protected health information, as well as unauthorized access to the data of several of Accellion's other clients. This incident led to putative class action lawsuits that were filed against us and our subsidiaries, Health Net, LLC, Health Net of California, Inc., HNL, Health Net Community Solutions, Inc., and California Health & Wellness, and Accellion on behalf of the affected customers. 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 us to state, federal, or international 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 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. A vulnerability in our service providers' 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 parties 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 operate and successfully 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 increased availability of hybrid or remote working arrangements has expanded the pool of companies that can compete for our team members and employment candidates. Our recently adopted 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. We have recorded a total of \$529 million in impairment charges during the year ended December 31, 2023, which were largely attributed to recent divestitures. For additional information, see Note 7. *Goodwill and Intangible Assets* 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 in funding, 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, TRICARE, CHIP, LTSS, ABD, Foster Care and Health Insurance Marketplace premiums. Changes in these programs could change the number of persons enrolled in or eligible for these programs and increase our administrative and healthcare costs under these programs. For example, due to the declaration of the end of the public health emergency (PHE) and the subsequent expiration of the eligibility determination waivers, we expect the resumption of the Medicaid eligibility redeterminations to significantly reduce our membership in our Medicaid programs. We do not expect to fully offset the loss of this membership by increased enrollment in our Health Insurance Marketplace products. States may decide to reduce reimbursement or reduce benefits in order for states to afford to maintain or increase eligibility levels. 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.

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. For example, 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. Governments periodically consider reducing or reallocating the amount of money they spend for Medicaid, Medicare, TRICARE, CHIP, LTSS, ABD and Foster Care. Additionally, as a result of the CMS Medicare Advantage 2024 rate decrease, combined with our quality scores, we have established a premium deficiency reserve in connection with the 2024 Medicare Advantage business as of December 31, 2023. Furthermore, 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.

The IRA enacts significant changes to the Medicare Part D program beginning on January 1, 2025. These changes create 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.

In addition, proposed CMS regulations may require beneficiaries dually enrolled in Medicare and Medicaid to receive integrated care through Medicare Advantage D-SNPs, which may restrict our product offerings in some geographic service areas.

In addition, reductions in defense spending could have an adverse impact on certain government programs in which we currently participate by, among other things, terminating or materially changing such programs, or by decreasing or delaying payments made under such programs. 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 in funding for programs, contraction of covered benefits 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, TRICARE, 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.

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. 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.

Significant changes or judicial challenges to the ACA 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, 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. The HHS additionally indicated that it would consider a limited number of premium assistance demonstration proposals from states that want to privatize Medicaid expansion. 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, with additional states pursuing Section 1115 waivers regarding eligibility criteria, benefits, and cost-sharing, and provider payments across their Medicaid programs. Litigation challenging Section 1115 waiver activity for both new and previously approved waivers is expected to continue both through administrative actions and the courts.

The enhanced eligibility for the advance premium tax credit for Marketplace members that was extended by the Inflation Reduction Act expires December 31, 2025. If this credit is not renewed or extended, or if eligibility for this credit is limited, it could materially adversely impact our Marketplace membership.

Additionally, the U.S. Department of Labor issued a final rule on June 19, 2018, which expanded flexibility regarding the regulation and formation of association health plans (AHPs) provided by small employer groups and associations. On June 13, 2019, the HHS, the U.S. Department of Labor and the U.S. Treasury issued a final rule allowing employers of all sizes that do not offer a group coverage plan to fund a new kind of health reimbursement arrangement (HRA), known as an individual coverage HRA (ICHRA). Beginning January 1, 2020, employees became able to use employer-funded ICHRAs to buy individual-market insurance, including insurance purchased on the public exchanges formed under the ACA. It remains uncertain whether or when the current or future administrations will propose changes to restrict these insurance plan options that are not required to meet ACA requirements, and what the impact of such potential changes may be.

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 and expanding navigator services, could impact our business and results of operations adversely or in other ways that we do not currently anticipate.

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. In addition, the managed care industry has received negative publicity that has led to increased legislation, regulation, review of industry practices and private litigation in the commercial sector. Such negative publicity may adversely affect our stock price and damage our reputation in various markets.

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. For example, our health plan subsidiaries must comply with minimum statutory capital and other financial solvency requirements, such as deposit and surplus requirements.

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, and increase or change our liability to members in the event of malpractice by our contracted providers. In addition, changes in political party, or administrations at the state or federal level in the United States or internationally may change the attitude towards healthcare programs and result in changes to the existing legislative or regulatory environment.

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

We are often required to maintain a minimum HBR 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 HBR 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.

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 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, under the ACA, Congress authorized CMS and the states to implement managed care demonstration programs to serve dually eligible beneficiaries to improve the coordination of their care. Participation in these demonstration programs is subject to CMS approval and the satisfaction of conditions to participation, including meeting certain performance requirements. 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 medical loss ratio 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. On November 13, 2020, CMS finalized revisions to the Medicaid managed care regulations, many of which became effective in December 2020. While not a wholesale revision of the 2016 regulations, the November 2020 final rule adopted changes in areas including network adequacy, beneficiary protections, quality oversight and the establishment of capitation rates and payment policies. 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.

In addition, as a result of the expansion of our businesses and operations conducted in foreign countries, we face political, economic, legal, compliance, regulatory, operational and other risks and exposures that are unique and vary by jurisdiction. These foreign regulatory requirements with respect to, among other items, environmental, tax, licensing, intellectual property, privacy, data protection, investment, capital, management control, labor relations, and fraud and corruption regulations are different than those faced by our domestic businesses. In addition, we are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the FCPA, and as well as anti-bribery and anti-corruption laws in other jurisdictions (such as the U.K. Bribery Act). Any failure to comply with laws and regulations governing our conduct outside the United States or to successfully navigate international regulatory regimes that apply to us could subject us to civil and criminal penalties and could adversely affect our ability to market our products and services, which may have a material adverse effect on our business, financial condition, and results of operations.

Our pharmacy services face regulatory and other competitive risks and uncertainties which could materially and adversely affect our results of operations, financial condition and cash flows.

We historically provided PBM services and continue to provide certain pharmacy benefits administration and specialty pharmacy services. We have transitioned substantially all of our PBM business to a third party as of January 1, 2023. These businesses are subject to federal and state laws and regulations that, among other requirements, govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers, and consumers. For example, several states have made claims related to PBM services including among other things, (i) claims seeking payment for services already reimbursed, (ii) claims alleging the failure to accurately disclose the true cost of the PBM services, and (iii) claims alleging inflation of dispensing fees for prescription drugs. For additional information, see Note 17. *Contingencies* to the consolidated financial statements included in Part II of this Annual Report on Form 10-K. Additional claims, reviews, or investigations may still be brought by other states, the federal government, or shareholder litigants.

Our specialty pharmacy business is 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 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, medical malpractice claims; claims by members and providers alleging failure to timely and accurately pay for or provide healthcare; claims related to non-payment or insufficient payments for out-of-network services; claims related to network adequacy; claims alleging bad faith; compliance with CMS Medicare and Marketplace regulations, including risk adjustment and broker compensation; claims related to the False Claims Act, the calculation of minimum MLR and rebates related thereto, claims related to privacy, intellectual property and vendor disputes; investigations regarding our submission of risk adjuster claims; putative securities class actions; protests and appeals related to Medicaid procurement awards; cybersecurity issues, including those related to our or our third-party vendors' information systems; employment-related disputes, including wage and hour claims; submissions to state agencies related to payments or state false claims acts, preauthorization penalties, timely review of grievance and appeals; and claims related to the imposition of new taxes, including but not limited to claims that may have retroactive application. For example, several states have made claims related to services previously provided by Envolve, which historically provided PBM and specialty pharmacy services, including among other things, (i) claims seeking payment for services already reimbursed, (ii) claims alleging the failure to accurately disclose the true cost of the PBM services and (iii) claims alleging inflation of dispensing fees for prescription drugs. For additional information, see Note 17. *Contingencies* to the consolidated financial statements included in Part II of this Annual Report on Form 10-K. Additional claims, reviews or investigations may be brought by other states, the federal government or shareholder litigants, and there is no guarantee we will have the ability to settle such claims with other states within the reserve estimate we have recorded, on other acceptable terms, or at all. 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 service providers 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, state and international 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, the GDPR and its equivalent in the United Kingdom (U.K. GDPR), which require us to protect the privacy of medical records and safeguard personal health information we maintain, use and otherwise process. 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 providers 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.

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.

We are subject to the data privacy laws of non-U.S. jurisdictions, such as the GDPR and U.K. GDPR, which impose stringent operational requirements on both data controllers and data processors and introduces significant penalties for non-compliance. While the GDPR and the U.K. GDPR remain substantially similar for the time being, the U.K. government has announced that it would seek to chart its own path on data protection and reform its relevant laws, including in ways that may differ from the GDPR. Legal developments in the European Economic Area (EEA) and the U.K. also have created complexity and uncertainty regarding processing and transfers of personal data from the EEA and the U.K. to the United States and other so-called third countries outside the EEA and the U.K. that have not been determined by the relevant data protection authorities to provide an adequate level of protection for privacy rights.

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 providers' 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.

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, TRICARE 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. In August 2022, the U.S. federal government enacted the Inflation Reduction Act, which imposed a 15% corporate minimum tax on certain large corporations and a 1% tax on share repurchases after December 31, 2022. The tax laws are extremely complex and subject to varying interpretations. We are 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 recent increases 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, 2023, we had consolidated indebtedness of \$17.8 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. Increases in interest rates have increased 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. Our Company Credit Facility also requires us to comply with a maximum debt to EBITDA ratio and a minimum fixed charge coverage ratio. These restrictive covenants could limit our ability to pursue our business strategies. In addition, any failure by us to comply with these restrictive covenants could result in an event of default under our 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

Previous or future acquisitions may not perform as expected and we may not realize the financial results expected from acquisitions or divestitures, which may cause the market price of our common stock to decline.

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.

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.

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 parties 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-reporting processes 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. Such reporting includes providing regular 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 quarterly 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 enterprise-wide risk management reports, which include significant cybersecurity risks, from our risk department multiple times per year. 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 15 years of experience leading information security programs and obtained the Certified Information Systems Security Professional certification ISC2. Our CISO, who has over 33 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 is used by each of our reportable segments. We generally lease space in the states where our health plans, specialty companies 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.

In connection with the adoption of a more modern, flexible work environment, we undertook a real estate optimization initiative in 2022 to evaluate future real estate needs and downsize our real estate footprint for owned and leased properties. As a result of this evaluation, we substantially changed the use of, or abandoned, various properties and recognized impairment charges for the years ended December 31, 2023 and 2022.

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 16, 2024, there were 1,012 holders of record of our common stock.

Issuer Purchases of Equity Securities

In November 2005, the Company's Board of Directors announced a stock repurchase program, which was most recently increased in December 2023. The Company is authorized to repurchase up to \$10.0 billion, inclusive of past authorizations, of which \$5.2 billion remains as of December 31, 2023.

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, 2023.

Issuer Purchases of Equity Securities
Fourth Quarter 2023
(Shares in thousands)

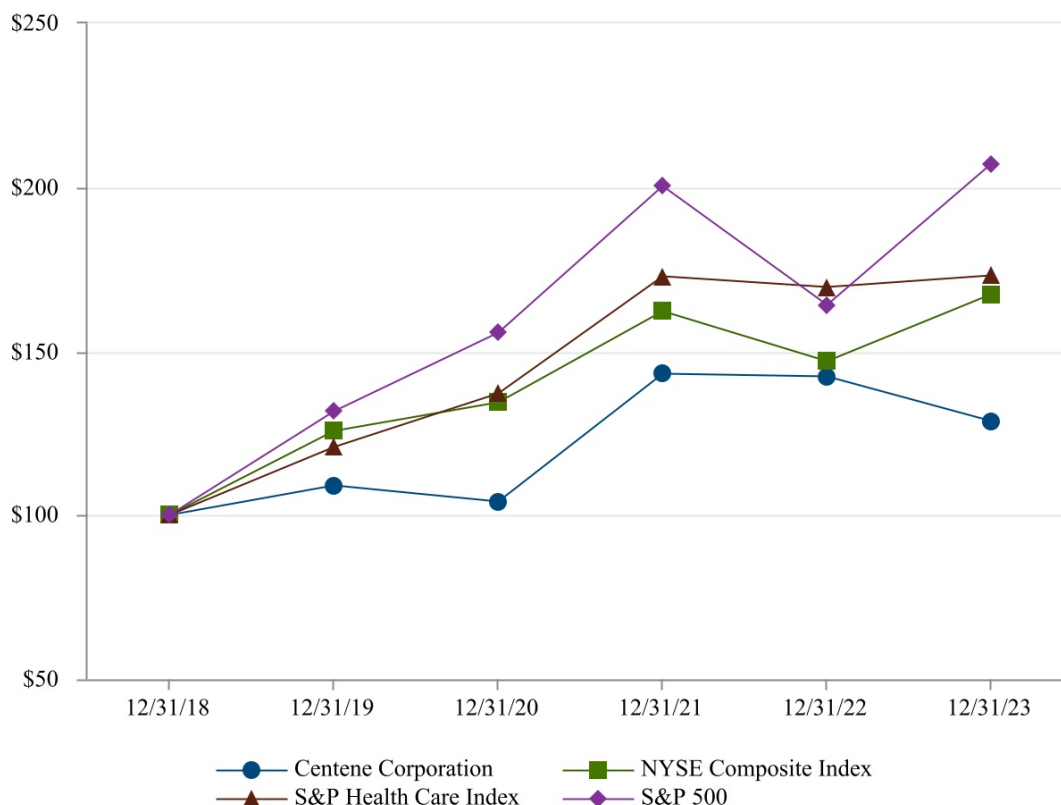
Execution Date	Total Number of Shares Purchased ⁽¹⁾	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs (\$ in millions) ⁽²⁾
October 1, 2023 - October 31, 2023	398	\$ 68.51	397	\$ 1,229
November 1, 2023 - November 30, 2023	1	71.14	—	1,229
December 1, 2023 - December 31, 2023	48	75.24	—	5,229
Total	447	\$ 69.25	397	\$ 5,229

⁽¹⁾ Includes 50 thousand shares relinquished to the Company by certain employees for payment of taxes.

⁽²⁾ In December 2023, the Company's Board of Directors authorized an additional \$4.0 billion increase to the stock repurchase program. A remaining amount of approximately \$5.2 billion is available under the stock repurchase program as of December 31, 2023.

Stock Performance Graph

The graph below compares the cumulative total stockholder return on our common stock for the period from December 31, 2018 to December 31, 2023, 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, 2018 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.



	December 31,					
	2018	2019	2020	2021	2022	2023
Centene Corporation	\$ 100.00	\$ 109.05	\$ 104.13	\$ 142.93	\$ 142.25	\$ 128.73
NYSE Composite Index	100.00	125.51	134.28	162.04	146.89	167.18
S&P Health Care Index	100.00	120.82	137.07	172.89	169.51	172.99
S&P 500	100.00	131.49	155.68	200.37	164.08	207.21
Centene Corporation closing stock price	\$ 57.65	\$ 62.87	\$ 60.03	\$ 82.40	\$ 82.01	\$ 74.21
Centene Corporation annual stockholder return	14.3%	9.1%	(4.5)%	37.3%	(0.5)%	(9.5)%

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, 2021, including year-to-year comparisons between the year ended December 31, 2022 and the year ended December 31, 2021. For a comparison of our results of operations for the fiscal years ended December 31, 2022 and December 31, 2021, 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, 2022, filed with the SEC on February 21, 2023.

EXECUTIVE OVERVIEW

We are a leading provider of government-sponsored healthcare. We provide access to quality healthcare for nearly 1 in 15 individuals nationwide through government-sponsored programs, including Medicaid, Medicare and the Health Insurance Marketplace. Our focus is on improving health and health care for low-income, complex populations.

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. Our uniquely local approach – with local brands and local teams who live in, care about and directly influence the communities they serve – is a key differentiator in our ability to provide access to quality care to our members. Centene treats the whole person, an approach that is delivered locally but backed by the scale of Centene's expertise, data and resources. Through this approach and our commitment to sustainable partnerships, we work with local community organizations to realize our mission of transforming the health of the communities we serve, one person at a time.

Our record of organic growth and strategic acquisitions has given us the size, scale and privilege of providing local high-quality and affordable health care to more than 27 million Americans. As of December 31, 2023, we were the largest Medicaid health insurer in the country, serving more than 14 million Medicaid recipients in 30 states. We were the largest Marketplace carrier, serving 3.9 million members across 28 states, served 1.3 million Medicare Advantage members across 36 states and 4.6 million Medicare Prescription Drug Plan (PDP) members in 50 states and the District of Columbia.

General

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.

Segments Update

In the first quarter of 2023, and in conjunction with our updated strategic plan, executive leadership realignment, and corresponding 2023 divestitures, we revised the way we manage the business, evaluate performance and allocate resources, resulting in an updated segment structure comprised of (1) a Medicaid segment, (2) a Medicare segment, (3) a Commercial segment and (4) an Other segment. We began reporting under this new segment structure in 2023. Prior year information has been adjusted to reflect the change in segment reporting.

Acquisitions and Divestitures

In December 2023, we completed the divestiture of Operose Health Group (Operose Health) and recognized an impairment of \$140 million, or \$128 million after-tax.

In August 2023, we signed a definitive agreement to sell Circle Health Group (Circle Health), which resulted in an impairment of \$292 million, or \$258 million after-tax, in 2023. The divestiture was completed in January 2024.

In June 2023, we completed the divestiture of our majority stake in Apixio and recognized a gain of \$93 million, or \$67 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.

In January 2023, we also completed the divestitures of Centurion and HealthSmart and recorded impairments of \$259 million (\$181 million after-tax) and \$36 million (\$27 million after-tax), respectively, in 2022. During 2023, we recognized a gain of \$15 million, or \$10 million after-tax, on the divestiture of the Centurion business reflecting additional proceeds for contingent consideration, partially offset by net working capital adjustments.

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 on the divestiture of \$22 million, or \$10 million after-tax, due to the finalization of working capital adjustments.

In November 2022, we divested our ownership stakes in our Spanish and Central European businesses and as a result recorded an impairment charge of \$163 million, or \$140 million after-tax. During 2023, we recognized an additional loss on sale of \$13 million, or \$10 million after-tax, related to the divestiture of our Spanish and Central European businesses.

In July 2022, we divested PANTHERx Rare (PANTHERx) for \$1.4 billion and recognized a gain of \$490 million, or \$382 million after-tax.

In January 2022, we acquired all of the issued and outstanding shares of Magellan Health, Inc. (Magellan). Total consideration for the acquisition was \$2.5 billion, consisting of \$2.4 billion in cash and \$60 million related to the fair value of replacement equity awards associated with pre-combination service.

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

Value Creation Plan

We established our Value Creation Plan to drive margin expansion by leveraging our scale and generating sustainable, profitable growth. In addition to creating shareholder value, this plan is an ongoing effort to modernize and improve how we work in order to propel our organization to new levels of success and elevate the member and provider experiences. During the twelve months ended December 31, 2023, we completed the following key milestones in our Value Creation Plan:

- Completed the divestitures of Magellan Specialty Health, Centurion, HealthSmart, our majority stake in Apixio and Operose Health. Additionally, during the third quarter of 2023, we signed a definitive agreement to sell Circle Health. The divestiture was completed in January 2024.
- Completed \$1.6 billion of common stock repurchases through our stock repurchase program, which were funded through divestiture proceeds and free cash flow generated from operations.
- Completed operating model changes initiated in 2022, including streamlining call center management and utilization management.
- Initiated standardization of our pharmacy operating model and completed an RFP for pharmacy benefits management (PBM) services. Our new third-party PBM contract commenced in January 2024.
- Launched our next-gen clinical population health platform.

Regulatory Trends and Uncertainties

The United States government, policymakers and healthcare experts continue to discuss and debate various elements of the United States healthcare model. We remain focused on the promise of delivering access to high-quality, affordable healthcare to all of our members and believe we are well positioned to meet the needs of the changing healthcare landscape.

In contrast to previous executive and legislative efforts to restrict or limit certain provisions of the Affordable Care Act (ACA), legislation and regulations at the federal level over the last few years have contained provisions aimed at leveraging Medicaid and the Health Insurance Marketplace to expand health insurance coverage and affordability to consumers. The American Rescue Plan Act (ARPA), enacted in March 2021, initially enhanced eligibility for the premium tax credit for enrollees in the Health Insurance Marketplace, which was extended through the 2025 tax year by the Inflation Reduction Act, enacted in August 2022.

In addition, proposed Centers for Medicare & Medicaid Services (CMS) regulations may require beneficiaries dually enrolled in Medicare and Medicaid to receive integrated care through Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), which may restrict our product offerings in some geographic service areas. We believe we are positioned well given our overlapping Medicaid and Medicare Advantage footprints and are committed to navigating evolving regulations.

The COVID-19 pandemic has impacted and continues to affect our business as it relates to Medicaid eligibility changes and vaccines and treatments. The Families First Coronavirus Response Act, enacted in March 2020, increased federal matching rates for state Medicaid programs with a requirement that states suspend Medicaid redeterminations throughout the public health emergency (PHE). As a result, since the onset of the 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). The Consolidated Appropriations Act, 2023, signed into law on December 29, 2022, delinked the Medicaid continuous coverage requirements from the PHE and, as a result, some states began Medicaid disenrollments on April 1, 2023. Per the Act and clarifying CMS guidance, redeterminations related to the PHE should conclude during the second quarter of 2024. Redeterminations in certain states may move at a slower pace due to CMS compliance action to pause and/or complete corrective action prior to disenrolling beneficiaries. Some states could see redeterminations extend past the second quarter of 2024 given CMS compliance actions.

We are actively engaged to help ensure individuals take the state agency requested action to confirm eligibility in their Medicaid coverage or find other appropriate coverage that is best for themselves and their families. Our Ambetter Health product covers the majority of our Medicaid states, and we believe we are among the best positioned in the healthcare market to enroll those transitioning coverage through redeterminations. Although Medicaid continuous coverage requirements were decoupled from the PHE, we are working to address provisions that were tied to the end of the PHE which expired on May 11, 2023, including COVID costs related to vaccines and treatments, coverage requirements and various other payment structures.

We also closely monitor state legislation across our markets and are advocating for and seeing adoption of coverage expansions for Medicaid adult populations (e.g., North Carolina), postpartum, foster care, children, among others, as well as mitigating adverse legislation addressing pharmacy, prior authorization and other issues.

We have more than three decades of experience, spanning seven presidents from both sides of the aisle, in delivering high-quality healthcare services on behalf of states and the federal government to under-insured and uninsured families, commercial organizations and military families. This expertise has allowed us to deliver cost-effective services to our government partners and our members. With trends in the personalization of healthcare technology, we continue the use of data and analytics to optimize our business. 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.

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

2023 Highlights

Our financial performance for 2023 is summarized as follows:

- Year-end membership of 27.5 million, an increase of 413 thousand members, or 2% over 2022.
- Total revenues of \$154.0 billion, representing 7% growth year-over-year.
- Premium and service revenues of \$140.1 billion, representing 3% growth year-over-year.
- HBR of 87.7% for 2023, compared to 87.7% for 2022.
- SG&A expense ratio of 9.0% for 2023, compared to 8.6% for 2022.
- Adjusted SG&A expense ratio of 8.9% for 2023, compared to 8.4% for 2022.
- Diluted earnings per share (EPS) of \$4.95 for 2023, compared to \$2.07 for 2022.
- Adjusted diluted EPS of \$6.68 for 2023, compared to \$5.78 for 2022, representing over 15% growth year-over-year.
- Operating cash flows of \$8.1 billion, or 3.0 times net earnings and 2.2 times adjusted net earnings, for 2023.

A reconciliation from GAAP diluted EPS to Adjusted Diluted EPS is highlighted below, and additional detail is provided under the heading "*Non-GAAP Financial Presentation*":

We reference 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,	
	2023	2022
GAAP diluted EPS attributable to Centene	\$ 4.95	\$ 2.07
Amortization of acquired intangible assets	1.32	1.40
Acquisition and divestiture related expenses	0.13	0.36
Other adjustments ⁽¹⁾	0.85	2.65
Income tax effects of adjustments ⁽²⁾	(0.57)	(0.70)
Adjusted Diluted EPS	\$ 6.68	\$ 5.78

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

2023:

- (a) Circle Health impairment of \$292 million, or \$0.53 per share (\$0.47 after-tax), 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).

2022:

(b) real estate impairments of \$1,642 million, or \$2.82 per share (\$2.08 after-tax), 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).

⁽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, 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.

Current and Future Operating Drivers

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

Medicaid

- In December 2023, our subsidiaries, Carolina Complete Health and WellCare of North Carolina, began providing coverage under North Carolina's new Medicaid Expansion program.
- In September 2023, our subsidiary, Superior HealthPlan (Superior), commenced a new, six-year contract awarded by the Texas Health and Human Services Commission to continue providing youth in foster care with healthcare coverage through the STAR Health Medicaid program. Superior has been the sole provider of STAR Health coverage since the program launched in 2008.
- In April 2023, eligibility redeterminations related to the PHE began. We expect that these redeterminations will extend over a 14-month period, with the majority of states concluding in the second quarter of 2024. Eligibility suspensions from the onset of the PHE drove increased membership through March 2023 followed by decreases beginning in April through the end of 2023.
- In April 2023, the state of New York removed pharmacy services for certain of our managed care contracts in connection with the state's transition of pharmacy services to Medicaid fee-for-service.
- In February 2023, our subsidiary, Buckeye Health Plan, commenced the Medicaid contract awarded by the Ohio Department of Medicaid to continue providing members with quality healthcare, coordinated services and benefits.
- In January 2023, our subsidiary, Delaware First Health, commenced its new contract for the statewide Medicaid managed care programs.
- In January 2023, our subsidiary, Louisiana Healthcare Connections, commenced the Medicaid contract awarded by the Louisiana Department of Health to continue administering quality, integrated healthcare services to members across the state.
- In January 2023, our subsidiary, Managed Health Services, commenced the contract awarded by the Indiana Department of Administration to continue serving Hoosier Healthwise and Health Indiana Plan members with Medicaid and Medicaid alternative managed care and care coordination services.
- In October 2022, the state of Ohio removed pharmacy services in connection with the state's transition from managed care to a single PBM.

- In July 2022, our subsidiary, Home State Health, commenced the MO HealthNet Managed Care General Plan and Specialty Plan contracts.

Medicare

- Medicare membership declined year-over-year due to lower enrollment during both the annual and open enrollment periods.

Commercial

- In 2023, our Health Insurance Marketplace product, Ambetter Health, expanded into Alabama and extended its footprint by more than 60 counties across 12 existing states. In total, the Marketplace plan is available in more than 1,500 counties across 28 states. Additionally, Marketplace membership increased year-over-year due to the expanded footprint, strong product positioning and open enrollment results, as well as overall market growth.

Other

- In June 2023, we completed the divestiture of Apixio. We maintain a close relationship with, and a minority interest in, the business.
- In January 2023, we completed the divestitures of Magellan Specialty Health, Centurion and HealthSmart.
- In December 2022, we completed the divestiture of Magellan Rx, which was part of the Magellan business acquired in January 2022.
- In November 2022, we completed the divestiture of our ownership stakes in our Spanish and Central European businesses, including Ribera Salud, Torrejón Salud and Pro Diagnostics Group.
- In July 2022, we completed the divestiture of PANTHERx.

We expect the following items to impact our future results of operations:

Medicaid

- In January 2024, our subsidiary, NH Healthy Families, was selected 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 (MCM). The contract is expected to begin in September 2024 for a five-year term.
- In January 2024, our subsidiary, Nebraska Total Care, commenced the statewide Medicaid managed care contract to continue serving the state's Medicaid Managed Care Program, known as Heritage Health. The initial contract term is five years and includes the option for two subsequent, one-year renewals, for a potential total of seven years.
- In January 2024, our subsidiary, Health Net of California, commenced direct Medicaid contracts in 10 counties, including Los Angeles (in which a portion is subcontracted).
- In January 2024, key coverage expansion provisions outlined in the 2022 year-end spending bill went into effect requiring states to provide 12 months of continuous coverage for children under Medicaid and Children's Health Insurance Program (CHIP). The spending bill also made the state option to extend coverage for postpartum women for up to 12 months permanent.
- In December 2023, our subsidiary, Arizona Complete Health, the largest Medicaid health plan in Arizona, 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 nearly 26,000 Arizonans who are elderly and/or have a physical disability (E/PD) with physical and behavioral healthcare, as well as provides pharmacy benefits. The new ALTCS-E/PD contract is anticipated to begin in October 2024, subject to the resolution of third-party protests, and is a three-year term with four optional one-year extensions, for a total of seven possible contract years.

- In July 2023, our subsidiary, Superior, announced it entered into a contract to continue to provide healthcare coverage to the aged, blind or disabled (ABD) population in the state's STAR+PLUS program. The contract is anticipated to begin in September 2024 for a six-year term with a maximum of three additional two-year extensions.
- In June 2023, our subsidiary, Oklahoma Complete Health, was selected by the Oklahoma Health Care Authority for statewide contracts to provide managed care for the SoonerSelect and SoonerSelect Children's Specialty Plan programs. The new contracts are anticipated to begin in April 2024 for a one-year term with five, one-year renewal options.
- In August 2022, our subsidiary, Magnolia Health Plan (Magnolia), was awarded the Mississippi Division of Medicaid contract. Under the new contract, Magnolia will continue serving the state's Coordinated Care Organization Program, which will consist of the Mississippi Coordinated Access Network and the Mississippi CHIP. The contract is anticipated to begin in January 2025, subject to the resolution of third-party protests.
- In August 2021, our subsidiaries, Carolina Complete Health and WellCare of North Carolina, were selected to coordinate physical and/or other health services with Local Management Entities/Managed Care Organizations under the state's new Tailored Plans. The Tailored Plans are integrated health plans designed for individuals with significant behavioral health needs and intellectual/developmental disabilities. The Tailored Plans are expected to commence no later than July 2024.

Medicare

- In October 2023, CMS issued 2024 Medicare Advantage Star Ratings on the Medicare Plan Finder. Based on the data, approximately 73% of membership is associated with contracts showing year-over-year unrounded score improvement, and approximately 87% of membership is associated with contracts rated 3.0 stars or better - compared to 53% in the prior year. While we have work to do to improve star scores, this demonstrated the first step towards our multi-year goals.
- The decrease in Star quality ratings in the 2023 rating year, which CMS published in October 2022, will adversely impact our 2024 Medicare revenue. The decrease in Star quality ratings is driven by the expiration of certain disaster relief provisions as well as deterioration in select metrics. Over the past year, our leadership team launched a multi-year plan to build and improve quality across the enterprise with a strong focus on enhanced patient experience and access to care. As a result of this expectation, we recorded a premium deficiency reserve of \$250 million in the fourth quarter of 2023 in connection with the 2024 Medicare Advantage business.

Other

- In December 2023 and January 2024, we completed the divestitures of Operose Health and Circle Health, respectively.
- In June 2023, our subsidiary, Magellan Health was awarded the Idaho Behavioral Health Plan contract. The contract is anticipated to begin in July 2024 for a four-year term.

The benefits of successful execution of our Value Creation Plan have impacted our current results of operations and will continue to impact future results of operations, including the implementation of our new third-party PBM contract, which commenced in January 2024.

MEMBERSHIP

From December 31, 2022 to December 31, 2023, our managed care membership increased by 413 thousand, or 2%. The following table sets forth our membership by line of business:

	December 31,	
	2023	2022
Traditional Medicaid ⁽¹⁾	12,754,000	14,264,800
High Acuity Medicaid ⁽²⁾	1,718,000	1,710,000
Total Medicaid ⁽⁴⁾	14,472,000	15,974,800
Commercial Marketplace	3,900,100	2,076,100
Commercial Group	427,500	441,100
Total Commercial	4,327,600	2,517,200
Medicare ⁽³⁾⁽⁴⁾	1,284,200	1,511,100
Medicare PDP	4,617,800	4,226,000
Total at-risk membership	24,701,600	24,229,100
TRICARE eligibles	2,773,200	2,832,300
Total	27,474,800	27,061,400

⁽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 Medicare Advantage and Medicare Supplement.

⁽⁴⁾ Medicaid and Medicare membership includes 1,276,700 and 1,291,300 dual-eligible beneficiaries for the periods ending December 31, 2023, and December 31, 2022, respectively.

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, 2023 and 2022, respectively, prepared in accordance with generally accepted accounting principles in the United States (GAAP) (\$ in millions, except per share data in dollars):

	2023	2022	% Change 2022-2023
Premium	\$ 135,636	\$ 127,131	7 %
Service	4,459	8,348	(47)%
Premium and service revenues	140,095	135,479	3 %
Premium tax	13,904	9,068	53 %
Total revenues	153,999	144,547	7 %
Medical costs	118,894	111,529	7 %
Cost of services	3,564	7,032	(49)%
Selling, general and administrative expenses	12,563	11,589	8 %
Depreciation expense	575	614	(6)%
Amortization of acquired intangible assets	718	817	(12)%
Premium tax expense	14,226	9,330	52 %
Impairment	529	2,318	(77)%
Earnings from operations	2,930	1,318	122 %
Investment and other income	1,393	1,279	9 %
Debt extinguishment	—	30	n.m.
Interest expense	(725)	(665)	9 %
Earnings before income tax expense	3,598	1,962	83 %
Income tax expense	899	760	18 %
Net earnings	2,699	1,202	125 %
Loss attributable to noncontrolling interests	3	—	n.m.
Net earnings attributable to Centene Corporation	\$ 2,702	\$ 1,202	125 %
Diluted earnings per common share attributable to Centene Corporation	\$ 4.95	\$ 2.07	139 %

n.m.: not meaningful

Year Ended December 31, 2023 Compared to Year Ended December 31, 2022

Total Revenues

Total revenues increased 7% in the year ended December 31, 2023, over the corresponding period in 2022 driven by 88% membership growth in the Marketplace business due to strong product positioning as well as overall market growth and increased Medicaid premium tax revenue. The revenue growth was partially offset by recent divestitures in the Other segment.

Operating Expenses

Medical Costs/HBR

The HBR for the year ended December 31, 2023 was 87.7%, compared to 87.7% in 2022. The 2023 HBR was positively impacted by growth in the Marketplace business, which runs at a lower HBR, and strong performance from pricing discipline and execution, offset by the \$250 million premium deficiency reserve recorded in connection with the 2024 Medicare Advantage business.

Cost of Services

Cost of services decreased by \$3.5 billion in the year ended December 31, 2023, compared to the corresponding period in 2022. The cost of service ratio for the year ended December 31, 2023 was 79.9%, compared to 84.2% in 2022. The decreases were driven by recent divestitures.

Selling, General & Administrative Expenses

The SG&A expense ratio was 9.0% for the year ended December 31, 2023, compared to 8.6% for the year ended December 31, 2022. The adjusted SG&A expense ratio was 8.9% for the year ended December 31, 2023, compared to 8.4% for the year ended December 31, 2022. The increases were driven by growth in the Marketplace business, which operates at a meaningfully higher SG&A ratio as compared to Medicaid, along with Medicare distribution costs. The increases were partially offset by ongoing SG&A reduction initiatives and continued leveraging of expenses over higher revenues.

Impairment

During the year ended December 31, 2023, we recorded total impairment charges of \$529 million, including a \$292 million charge related to assets associated with the divestiture of Circle Health, a \$140 million charge related to the Operose Health divestiture and additional impairments of \$97 million related to our ongoing real estate optimization initiative.

During the year ended December 31, 2022, we recorded total impairment charges of \$2.3 billion primarily driven by \$1.6 billion related to the reduction of our real estate footprint consisting of leased and owned real estate assets and related fixed assets. Additionally, we recorded impairment charges associated with the divestitures of our Spanish and Central European, Centurion and HealthSmart businesses of \$458 million. We also recorded a \$233 million impairment charge related to Health Net Federal Services business as a result of the Department of Defense's (DoD) December 2022 announcement to not award Health Net Federal Services a TRICARE Managed Care Support Contract.

Other Income (Expense)

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

	2023	2022
Investment and other income	\$ 1,393	\$ 1,279
Debt extinguishment	—	30
Interest expense	(725)	(665)
Other income (expense), net	<u>\$ 668</u>	<u>\$ 644</u>

Investment and other income. Investment and other income increased by \$114 million for the year ended December 31, 2023 compared to 2022, driven by higher interest rates on larger investment balances, a \$93 million gain on the sale of Apixio, a \$79 million gain on the sale of Magellan Specialty Health and a \$15 million gain on the sale of Centurion, partially offset by a \$75 million realized loss on the sale of investments from rebalancing a portion of our portfolio with a focus on higher interest rate investments, a \$22 million reduction to the previously reported gain on the sale of Magellan Rx and an additional loss on the sale of our Spanish and Central European businesses of \$13 million. The year ended December 31, 2022 included a \$490 million gain on the sale of PANTHERx and a \$269 million gain on the sale of Magellan Rx.

Debt extinguishment. In 2022, we repurchased \$95 million of our 4.25% Senior Notes due 2027 and \$223 million of our 4.625% Senior Notes due 2029 through our senior note debt repurchase program, resulting in a gain on extinguishment of \$14 million. Additionally, we recognized a \$13 million gain on the extinguishment of debt related to the refinancing of debt for our Circle Health subsidiary. The 2022 debt extinguishment also includes an immaterial gain related to the redemption of Magellan's outstanding Senior Notes in January 2022.

Interest expense. Interest expense for the year ended December 31, 2023 was \$725 million compared to \$665 million for the corresponding period in 2022. The increase was driven by higher interest rates on variable rate debt.

Income Tax Expense

For the year ended December 31, 2023, we recorded an income tax expense of \$899 million on pre-tax earnings of \$3.6 billion, or an effective tax rate of 25.0%. The effective tax rate for the year ended December 31, 2023 reflects the tax effects of the distribution of long-term stock awards to the estate of the Company's former CEO, divestiture gains and losses, lower state taxes and the pending divestiture of Circle Health. For the year ended December 31, 2023, our effective tax rate on adjusted earnings was 24.9%.

For the year ended December 31, 2022, we recorded income tax expense of \$760 million on pre-tax earnings of \$2.0 billion, or an effective tax rate of 38.7%, which reflected the tax effects of divestitures and impairments including the Magellan Rx divestiture gain, the non-deductible impairment of our Health Net Federal Services business, and tax impacts related to the reclassification of the Magellan Specialty Health Business to held for sale. For the year ended December 31, 2022, our effective tax rate on adjusted earnings was 25.8%.

Segment Results

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

	2023	2022	% Change 2022-2023
Total Revenues			
Medicaid	\$ 100,759	\$ 93,151	8 %
Medicare	22,261	22,484	(1)%
Commercial	24,845	17,380	43 %
Other	6,134	11,532	(47)%
Consolidated Total	<u>\$ 153,999</u>	<u>\$ 144,547</u>	<u>7 %</u>
Gross Margin ⁽¹⁾			
Medicaid	\$ 8,641	\$ 8,785	(2)%
Medicare	2,867	3,112	(8)%
Commercial	5,029	3,288	53 %
Other	1,100	1,733	(37)%
Consolidated Total	<u>\$ 17,637</u>	<u>\$ 16,918</u>	<u>4 %</u>

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

Medicaid

Total revenues increased 8% in the year ended December 31, 2023, compared to the corresponding period in 2022 due to increased premium tax revenue, net rate increases, and expansions and new programs in various states in 2023, including California and North Carolina, and the commencement of our contract in Delaware, partially offset by Medicaid membership redeterminations and pharmacy carve outs in early 2023. Gross margin decreased \$144 million in the year ended December 31, 2023, compared to the corresponding period in 2022 primarily driven by acuity shifts due to redeterminations, net of rate actions.

Medicare

Total revenues decreased 1% in the year ended December 31, 2023, compared to the corresponding period in 2022. Gross margin decreased \$245 million in the year ended December 31, 2023, compared to the corresponding period in 2022 driven primarily by the premium deficiency reserve recorded in connection with the 2024 Medicare Advantage business.

Commercial

Total revenues increased 43% in the year ended December 31, 2023, compared to the corresponding period in 2022. Gross margin increased \$1.7 billion in the year ended December 31, 2023, compared to the corresponding period in 2022. Increases were primarily driven by 88% membership growth in the Marketplace business, resulting from strong product positioning and overall market growth.

Other

Total revenues decreased 47% in the year ended December 31, 2023, compared to the corresponding period in 2022. Gross margin decreased \$633 million in the year ended December 31, 2023, compared to the corresponding period in 2022. Decreases were primarily due to recent divestitures.

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,	
	2023	2022
Net cash provided by operating activities	\$ 8,053	\$ 6,261
Net cash (used in) investing activities	(1,191)	(2,921)
Net cash (used in) financing activities	(1,658)	(4,197)
Effect of exchange rate changes on cash, cash equivalents and restricted cash	(32)	(11)
Net increase (decrease) in cash, cash equivalents, and restricted cash and cash equivalents	<u>\$ 5,172</u>	<u>\$ (868)</u>

Cash Flows Provided by Operating Activities

Normal operations are funded primarily through operating cash flows and borrowings under our Revolving Credit Facility. In 2023, operating activities provided cash of \$8.1 billion, or 3.0 times net earnings and 2.2 times adjusted net earnings, compared to \$6.3 billion in 2022. Cash flows provided by operations in 2023 were primarily driven by net earnings, an increase in risk adjustment payable for Marketplace and the timing of pass-through payments.

Cash flows provided by operations in 2022 were driven by net earnings before the non-cash real estate and divestiture related impairment charges and an increase in medical claims liabilities driven by the timing of claims payments.

Cash Flows (Used in) Investing Activities

Investing activities used cash of \$1.2 billion for the year ended December 31, 2023 and \$2.9 billion in 2022. Cash flows used in investing activities in 2023 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.

Cash flows used in investing activities in 2022 primarily consisted of the net additions to the investment portfolio of our regulated subsidiaries and our acquisition of Magellan, partially offset by PANTHERx and Magellan Rx divestiture proceeds.

We spent \$799 million and \$1.0 billion in the years ended December 31, 2023 and 2022, respectively, on capital expenditures primarily for system enhancements and computer hardware.

As of December 31, 2023, our investment portfolio consisted primarily of fixed-income securities with a weighted average duration of 3.4 years. We had unregulated cash and investments of \$1.0 billion at December 31, 2023, the majority of which was utilized in January 2024 to complete planned pass-through payments. At December 31, 2022, we had unregulated cash and investments of \$1.4 billion, the majority of which was utilized in January 2023 to complete planned pass-through payments. 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 \$1.7 billion in the year ended December 31, 2023, compared to using cash of \$4.2 billion in the comparable period in 2022. Financing activities in 2023 were driven by stock repurchases of \$1.6 billion.

In 2022, financing activities were driven by stock repurchases of \$3.0 billion, the redemption of Magellan's outstanding debt of \$535 million assumed in the transaction using Magellan's cash on hand, senior note debt repurchases of \$318 million and the repayment of our construction loan.

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, the Company's Board of Directors authorized up to a cumulative total of \$10.0 billion of repurchases under the program.

In 2023, we repurchased a total of 22.9 million shares of common stock for \$1.6 billion under the stock repurchase program, primarily funded through divestiture proceeds and free cash flow generated from operations. We have approximately \$5.2 billion remaining under the program as of December 31, 2023. 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, 2023, we had an aggregate principal amount of \$15.7 billion of senior notes issued and outstanding. The indentures governing our various maturities of senior notes contain limited restrictive covenants. As of December 31, 2023, 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, the Company's Board of Directors authorized a \$1.0 billion senior note debt repurchase program. No repurchases were made during the year ended December 31, 2023. As of December 31, 2023, there was \$700 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.

The credit agreement underlying our Revolving Credit Facility and Term Loan Facility contains customary covenants, as well as financial covenants, including, a minimum fixed charge coverage ratio and a maximum debt to EBITDA ratio. Our maximum debt to EBITDA ratio under the credit agreement may not exceed 4.0 to 1.0. As of December 31, 2023, we had \$150 million of borrowings outstanding under our Revolving Credit Facility, \$2.1 billion of borrowings outstanding under our Term Loan Facility and we were in compliance with all covenants. As of December 31, 2023, there were no limitations on the availability of our Revolving Credit Facility as a result of the debt to EBITDA ratio.

We had outstanding letters of credit of \$152 million as of December 31, 2023, which were not part of our Revolving Credit Facility. The letters of credit bore weighted interest of 0.7% as of December 31, 2023. In addition, we had outstanding surety bonds of \$856 million as of December 31, 2023.

At December 31, 2023, our debt to capital ratio, defined as total debt divided by the sum of total debt and total equity, was 40.7%, compared to 42.7% at December 31, 2022. The debt to capital ratio decrease was driven by net earnings and other comprehensive earnings, partially offset by stock repurchases in 2023. We utilize the debt to capital ratio as a measure, among others, of our leverage and financial flexibility.

At December 31, 2023, we had working capital, defined as current assets less current liabilities, of \$4.0 billion, compared to \$1.7 billion at December 31, 2022. We manage our short-term and long-term investments with the goal of ensuring that a sufficient portion is held in investments that are highly liquid and can be sold to fund short-term requirements as needed.

During the years ended December 31, 2023 and 2022, we received dividends of \$2.3 billion and \$1.6 billion, respectively, from our regulated subsidiaries.

2024 Expectations

During 2024, we expect to receive net dividends of approximately \$3.0 billion from our regulated subsidiaries and expect to spend approximately \$640 million in capital expenditures primarily associated with system enhancements.

We have material debt, short-term medical claims, lease and contingencies obligations. Refer to Note 10. *Debt*, Note 8. *Medical Claims Liability*, Note 11. *Leases* and Note 17. *Contingencies*, 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. Our long-term liquidity position is stable, with our senior notes maturing between December 2027 and August 2031, and our Revolving Credit Facility maturing in August 2026. 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.

Our strategic approach is to continue to target initiatives to improve productivity, efficiencies and reduced organizational costs, as well as execute on capital deployment activities, including stock repurchases and the evaluation of portfolio and refinancing opportunities. In addition to creating shareholder value, this approach encompasses a larger organizational mission to enhance our member and provider experience, improve outcomes for our members and to initiate new ways of doing business that make Centene a great partner in all aspects of our operations.

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, 2023, our subsidiaries had aggregate statutory capital and surplus of \$18.1 billion, compared with the required minimum aggregate statutory capital and surplus requirements of \$8.3 billion. During the year ended December 31, 2023, we received dividends of \$2.3 billion from and made \$440 million 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, 2023, 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, 2023, the amount of capital and surplus or net worth that was unavailable for the payment of dividends or return of capital to us was \$8.3 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 our 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, 2023, we had \$17.6 billion of goodwill and \$6.1 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	3 - 21 years
Provider contracts	4 - 15 years
Trade names	7 - 20 years
Developed technologies	2 - 7 years

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, such as the discount factor, future utility and other internal and external factors, in determining the estimated fair values. While we believe these assumptions and estimates are appropriate, other assumptions and estimates could be applied and might produce significantly different results.

In the first quarter of 2023, and in conjunction with our updated strategic plan, executive leadership realignment and corresponding 2023 divestitures, we revised the way we manage the business, evaluate performance and allocates resources, resulting in an updated segment structure comprised of (1) a Medicaid segment, (2) a Medicare segment, (3) a Commercial segment and (4) an Other segment. As a result of these changes, we reassigned goodwill to the impacted reporting units using a relative fair value allocation approach.

Goodwill is reviewed annually during the fourth quarter for impairment. In addition, an impairment analysis of intangible assets would be performed based on other factors. These factors include significant changes in membership, financial performance, state funding, medical contracts and provider networks and contracts.

If a reporting unit's carrying amount exceeds its fair value, an entity 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, such as recent acquisitions, we may elect to perform a quantitative assessment without first assessing qualitative factors.

We do not believe any of our reporting units are currently at risk for 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. For older periods, we utilize an estimated completion factor 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, we have limited information with which to estimate our medical claims liability. See "Risk Factors - *Failure to accurately estimate and price our medical expenses or effectively manage our medical costs or related administrative costs 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 establish 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. In December 2023, we recorded a premium deficiency reserve of \$250 million related to the 2024 Medicare Advantage contract year.

The paid and received completion factors, claims per member per month and per diem 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, 2023 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)%	\$	1,161	(1.00)%	\$	(224)
(0.75)		867	(0.75)		(168)
(0.50)		575	(0.50)		(112)
(0.25)		286	(0.25)		(56)
0.25		(284)	0.25		56
0.50		(565)	0.50		112
0.75		(844)	0.75		168
1.00		(1,120)	1.00		224

⁽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 \$135 million for the year ended December 31, 2023, 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 observance 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,		
	2023	2022	2021
Balance, January 1,	\$ 16,745	\$ 14,243	\$ 12,438
Less: Reinsurance recoverables	26	23	23
Balance, January 1, net	16,719	14,220	12,415
Acquisitions and divestitures	—	105	—
Incurred related to:			
Current year	120,680	112,896	100,385
Prior years	(2,036)	(1,367)	(1,783)
Total incurred	118,644	111,529	98,602
Paid related to:			
Current year	104,725	97,799	87,427
Prior years	12,937	11,336	9,370
Total paid	117,662	109,135	96,797
Plus: Premium deficiency reserve	250	—	—
Balance, December 31, net	17,951	16,719	14,220
Plus: Reinsurance recoverables	49	26	23
Balance, December 31,	\$ 18,000	\$ 16,745	\$ 14,243
Days in claims payable ⁽¹⁾	54	54	52

⁽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 physician or other healthcare provider. As a result, the liability generally is described as having a "short-tail," which 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 substantially all the development of the estimate of medical claims liability as of December 31, 2023 will be known by the end of 2024.

Changes in estimates of incurred claims for prior years are primarily attributable to reserving under moderately adverse conditions. Additionally, as a result of minimum HBR and other return of premium programs, approximately \$382 million, \$198 million and \$492 million of the "Incurred related to: Prior years" was recorded as a reduction to premium revenues in 2023, 2022 and 2021, 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 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.

The following are examples of population health management initiatives that may have contributed to the favorable development through lower medical utilization and cost trends:

- Appropriate leveling of care for neonatal intensive care unit hospital admissions, other inpatient hospital admissions and observation admissions, in accordance with InterQual or other evidence-based criteria or clinical policy.
- Management of our pre-authorization list, monitoring for over-utilized services and stringent review of durable medical equipment and injectables.
- Emergency department programs designed to collaboratively work with hospitals and members to steer non-emergent care to a more appropriate and cost effective setting (through patient education, on-site alternative urgent care settings, etc.).
- Increased emphasis on care management and clinical rounding where nurse or social worker care managers assist selected high-risk members with the coordination of healthcare services in order to meet a patient's specific healthcare needs.
- Incorporation of disease management, which is a comprehensive, multidisciplinary, collaborative approach to chronic illnesses such as asthma.
- Prenatal and infant health programs.

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 product 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 may require us to maintain a minimum HBR or may require us to share cost-savings in excess of certain levels. In certain circumstances, including commercial plans, 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 continuously 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.

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. Approximately nine to ten months subsequent to the end of the plan year, or later in the case of the coverage gap discount subsidy, a settlement payment is made between CMS and our plans based on the difference between the prospective payments and actual claims experience.

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. We recognize revenue related to administrative services under the TRICARE government-sponsored Managed Care Support Contract for the DoD's TRICARE program on a straight-line basis over the option period, when the fees become fixed and determinable. The TRICARE contract includes various performance-based measures. For each of the measures, an estimate of the amount that has been earned is made at each interim date, and revenue is recognized accordingly.

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, 2023, we had short-term investments of \$2.4 billion and long-term investments of \$17.7 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, 2023, the fair value of our fixed income investments would decrease by approximately \$630 million. Declines in interest rates over time will reduce our investment income.

As of December 31, 2023, we had a foreign currency swap for a notional amount of \$931 million with a creditworthy financial institution to manage foreign exchange risk related to the proceeds from the then-pending Circle Health divestiture. As a result, the fair value of the swap varies with foreign exchange rate fluctuations. Assuming a 1% increase in the Great British Pound to US Dollar foreign exchange rate at December 31, 2023, the fair value of our swap would have decreased by approximately \$9 million. An increase in the US Dollar to Great British Pound foreign exchange rate decreases the fair value of the swap and conversely, a decrease in the foreign currency exchange rate increases the value. We do not hold or issue any derivative instruments for trading or speculative purposes. The foreign currency swap settled in January 2024 in conjunction with the closing of the Circle Health divestiture.

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, 2023 and 2022, 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, 2023, 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, 2023 and 2022, and the results of its operations and its cash flows for each of the years in the three-year period ended December 31, 2023, 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, 2023, 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 20, 2024 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, 2023 was \$18,000 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, 2023 ACA risk adjustment accruals is scheduled to be determined by the Centers for Medicare and Medicaid Services (CMS) in June 2024, based on data submitted by insurance companies through April 2024. As discussed in Note 9, the Company recorded an estimated asset and liability (the ACA risk adjustment accruals) of \$893 million, and \$2,553 million, respectively at December 31, 2023.

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.

/s/ KPMG LLP

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

St. Louis, Missouri
February 20, 2024

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

	<u>December 31, 2023</u>	<u>December 31, 2022</u>
ASSETS		
Current assets:		
Cash and cash equivalents	\$ 17,193	\$ 12,074
Premium and trade receivables	15,532	13,272
Short-term investments	2,459	2,321
Other current assets	5,572	2,461
Total current assets	40,756	30,128
Long-term investments	16,286	14,684
Restricted deposits	1,386	1,217
Property, software and equipment, net	2,019	2,432
Goodwill	17,558	18,812
Intangible assets, net	6,101	6,911
Other long-term assets	535	2,686
Total assets	<u>\$ 84,641</u>	<u>\$ 76,870</u>
LIABILITIES, REDEEMABLE NONCONTROLLING INTERESTS AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	\$ 18,000	\$ 16,745
Accounts payable and accrued expenses	16,420	9,525
Return of premium payable	1,462	1,634
Unearned revenue	715	478
Current portion of long-term debt	119	82
Total current liabilities	36,716	28,464
Long-term debt	17,710	17,938
Deferred tax liability	641	615
Other long-term liabilities	3,618	5,616
Total liabilities	58,685	52,633
Commitments and contingencies		
Redeemable noncontrolling interests	19	56
Stockholders' equity:		
Preferred stock, \$0.001 par value; authorized 10,000 shares; no shares issued or outstanding at December 31, 2023 and December 31, 2022	—	—
Common stock, \$0.001 par value; authorized 800,000 shares; 615,291 issued and 534,484 outstanding at December 31, 2023, and 607,847 issued and 550,754 outstanding at December 31, 2022	1	1
Additional paid-in capital	20,304	20,060
Accumulated other comprehensive (loss)	(652)	(1,132)
Retained earnings	12,043	9,341
Treasury stock, at cost (80,807 and 57,093 shares, respectively)	(5,856)	(4,213)
Total Centene stockholders' equity	25,840	24,057
Nonredeemable noncontrolling interest	97	124
Total stockholders' equity	25,937	24,181
Total liabilities, redeemable noncontrolling interests and stockholders' equity	<u>\$ 84,641</u>	<u>\$ 76,870</u>

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,		
	2023	2022	2021
Revenues:			
Premium	\$ 135,636	\$ 127,131	\$ 112,319
Service	4,459	8,348	5,664
Premium and service revenues	140,095	135,479	117,983
Premium tax	13,904	9,068	7,999
Total revenues	153,999	144,547	125,982
Expenses:			
Medical costs	118,894	111,529	98,602
Cost of services	3,564	7,032	4,894
Selling, general and administrative expenses	12,563	11,589	9,601
Depreciation expense	575	614	565
Amortization of acquired intangible assets	718	817	770
Premium tax expense	14,226	9,330	8,287
Impairment	529	2,318	229
Legal settlement	—	—	1,250
Total operating expenses	151,069	143,229	124,198
Earnings from operations	2,930	1,318	1,784
Other income (expense):			
Investment and other income	1,393	1,279	819
Debt extinguishment	—	30	(125)
Interest expense	(725)	(665)	(665)
Earnings before income tax	3,598	1,962	1,813
Income tax expense	899	760	477
Net earnings	2,699	1,202	1,336
Loss attributable to noncontrolling interests	3	—	11
Net earnings attributable to Centene Corporation	\$ 2,702	\$ 1,202	\$ 1,347
Net earnings per common share attributable to Centene Corporation:			
Basic earnings per common share	\$ 4.97	\$ 2.09	\$ 2.31
Diluted earnings per common share	\$ 4.95	\$ 2.07	\$ 2.28
Weighted average number of common shares outstanding:			
Basic	543,319	575,191	582,832
Diluted	545,704	582,040	590,516

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,		
	2023	2022	2021
Net earnings	\$ 2,699	\$ 1,202	\$ 1,336
Change in unrealized gain (loss) on investments	520	(1,475)	(296)
Change in unrealized gain (loss) on investments, tax effect	(128)	349	75
Change in unrealized gain (loss) on investments, net of tax	392	(1,126)	(221)
Reclassification adjustment, net of tax	62	11	(20)
Foreign currency translation adjustments, net of tax	36	(94)	(19)
Net unrealized (loss) on cash flow hedge, net of tax	(10)	—	—
Other comprehensive earnings (loss)	480	(1,209)	(260)
Comprehensive earnings (loss)	3,179	(7)	1,076
Comprehensive loss attributable to noncontrolling interests	3	—	11
Comprehensive earnings (loss) attributable to Centene Corporation	<u>\$ 3,182</u>	<u>\$ (7)</u>	<u>\$ 1,087</u>

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			Additional Paid-in Capital	Accumulated Other Comprehensive Earnings (Loss)	Retained Earnings	Treasury Stock		Noncontrolling Interest	Total
	\$0.001 Par Value Shares	Amt	Amt				\$0.001 Par Value Shares	Amt		
Balance, December 31, 2020	598,249	\$ 1	\$ 19,459	\$ 337	\$ 6,792	16,770	\$ (816)	\$ 112	\$ 25,885	
Net earnings (loss)	—	—	—	—	1,347	—	—	(21)	1,326	
Other comprehensive loss, net of \$(75) tax	—	—	—	(260)	—	—	—	—	(260)	
Common stock issued for employee benefit plans	4,781	—	38	—	—	—	—	—	38	
Common stock repurchases	(326)	—	(19)	—	—	3,455	(278)	—	(297)	
Stock compensation expense	—	—	203	—	—	—	—	—	203	
Contribution from noncontrolling interest	—	—	—	—	—	—	—	46	46	
Divestiture of noncontrolling interest	—	—	(9)	—	—	—	—	5	(4)	
Acquisition resulting in noncontrolling interest	—	—	—	—	—	—	—	3	3	
Balance, December 31, 2021	602,704	\$ 1	\$ 19,672	\$ 77	\$ 8,139	20,225	\$ (1,094)	\$ 145	\$ 26,940	
Net earnings (loss)	—	—	—	—	1,202	—	—	(13)	1,189	
Other comprehensive loss, net of \$(349) tax	—	—	—	(1,209)	—	—	—	—	(1,209)	
Common stock issued for employee benefit plans	5,143	—	71	—	—	—	—	—	71	
Fair value of unvested equity awards in connection with acquisition	—	—	60	—	—	—	—	—	60	
Common stock repurchases	—	—	23	—	—	36,868	(3,119)	—	(3,096)	
Stock compensation expense	—	—	234	—	—	—	—	—	234	
Reclassification to non-redeemable	—	—	—	—	—	—	—	17	17	
Divestiture of noncontrolling interest	—	—	—	—	—	—	—	(14)	(14)	
Dividend to noncontrolling interest	—	—	—	—	—	—	—	(10)	(10)	
Purchase of noncontrolling interest	—	—	—	—	—	—	—	(1)	(1)	
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	

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,		
	2023	2022	2021
Cash flows from operating activities:			
Net earnings	\$ 2,699	\$ 1,202	\$ 1,336
Adjustments to reconcile net earnings to net cash provided by operating activities			
Depreciation and amortization	1,293	1,430	1,335
Stock compensation expense	216	234	203
Impairment	529	2,318	229
(Gain) loss on debt extinguishment	—	(25)	125
(Gain) on acquisition	—	(2)	(309)
Deferred income taxes	(78)	(631)	(132)
(Gain) loss on divestitures, net	(152)	(772)	(88)
Loss on disposal of equipment	—	221	12
Other adjustments, net	172	(31)	(23)
Changes in assets and liabilities			
Premium and trade receivables	(2,380)	(1,627)	(2,453)
Other assets	5	128	(99)
Medical claims liabilities	1,261	2,397	1,802
Unearned revenue	238	31	(109)
Accounts payable and accrued expenses	3,398	421	1,141
Other long-term liabilities	856	842	1,093
Other operating activities, net	(4)	125	142
Net cash provided by operating activities	<u>8,053</u>	<u>6,261</u>	<u>4,205</u>
Cash flows from investing activities:			
Capital expenditures	(799)	(1,004)	(910)
Purchases of investments	(6,622)	(6,736)	(7,400)
Sales and maturities of investments	5,523	3,802	5,458
Acquisitions, net of cash acquired	—	(1,460)	(534)
Divestiture proceeds, net of divested cash	707	2,477	68
Other investing activities, net	—	—	19
Net cash (used in) investing activities	<u>(1,191)</u>	<u>(2,921)</u>	<u>(3,299)</u>
Cash flows from financing activities:			
Proceeds from long-term debt	2,335	360	9,267
Payments and repurchases of long-term debt	(2,316)	(1,490)	(7,434)
Common stock repurchases	(1,633)	(3,096)	(297)
Proceeds from common stock issuances	44	70	35
Payments for debt extinguishment	—	(14)	(157)
Purchase of noncontrolling interest	(88)	—	—
Debt issuance costs	—	—	(72)
Other financing activities, net	—	(27)	20
Net cash (used in) provided by financing activities	<u>(1,658)</u>	<u>(4,197)</u>	<u>1,362</u>
Effect of exchange rate changes on cash, cash equivalents and restricted cash	(32)	(11)	(11)
Net increase (decrease) in cash, cash equivalents and restricted cash and cash equivalents	<u>5,172</u>	<u>(868)</u>	<u>2,257</u>
Cash and cash equivalents reclassified (to) from held for sale	(50)	(16)	—
Cash, cash equivalents and restricted cash and cash equivalents, beginning of period	<u>12,330</u>	<u>13,214</u>	<u>10,957</u>
Cash, cash equivalents and restricted cash and cash equivalents, end of period	<u>\$ 17,452</u>	<u>\$ 12,330</u>	<u>\$ 13,214</u>
Supplemental disclosures of cash flow information:			
Interest paid	\$ 688	\$ 657	\$ 658
Income taxes paid	\$ 883	\$ 1,222	\$ 678
Equity issued in connection with acquisitions	\$ —	\$ 60	\$ —
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:			
	2023	2022	2021
Cash and cash equivalents	\$ 17,193	\$ 12,074	\$ 13,118
Restricted cash and cash equivalents, included in restricted deposits	259	256	96
Total cash, cash equivalents, and restricted cash and cash equivalents	<u>\$ 17,452</u>	<u>\$ 12,330</u>	<u>\$ 13,214</u>

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

CENTENE CORPORATION AND SUBSIDIARIES
NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS

1. Organization and Operations

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

In the first quarter of 2023, and in conjunction with the Company's updated strategic plan, executive leadership realignment and corresponding 2023 divestitures, the Company revised the way it manages the business, evaluates performance and allocates resources, resulting in an updated segment structure comprised of (1) a Medicaid segment, (2) a Medicare segment, (3) a Commercial segment and (4) an Other segment.

The Medicaid, Medicare and Commercial segments 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 Medicare segment includes Medicare Advantage, Medicare Supplement, Dual Eligible Special Needs Plans (D-SNPs) and Medicare Prescription Drug Plans (PDPs), also known as Medicare Part D. The Commercial segment includes the Health Insurance Marketplace product along with individual, small group and large group commercial health insurance products. The Other segment includes the Company's pharmacy operations, Envolve Benefit Options' vision and dental services, clinical healthcare, behavioral health, international operations and corporate management company, among others.

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 amounts in the consolidated financial statements and notes have been reclassified to conform to the 2023 presentation, including reclassifications related to the Company's new segment reporting structure as outlined in Note 1. *Organization and Operations*. Additionally, beginning in 2022, the Company included a separate line item for depreciation expense in the Consolidated Statements of Operations, which was previously included in selling, general and administrative (SG&A) expenses. Prior period SG&A expense ratios have also been conformed to the current presentation. These reclassifications have no effect on net earnings, cash flow or stockholders' equity as previously reported.

During 2023, the Company completed the divestitures of HealthSmart, Centurion, Magellan Specialty Health, its majority stake in Apixio, and Operose Health Group (Operose Health). Additionally, during the third quarter of 2023, the Company signed a definitive agreement to sell Circle Health Group (Circle Health), which was accounted for as held for sale as of December 31, 2023. On January 12, 2024, the Company completed the divestiture for cash consideration of \$931 million. During 2022, the Company acquired all of the issued and outstanding shares of Magellan Health, Inc. (Magellan). The acquisition was accounted for as a business combination. Additionally, during 2022 the Company completed the divestitures of PANTHERx Rare (PANTHERx), its Spanish and Central European businesses and Magellan Rx. 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.
- Foreign currency swap: Estimated based on Great British Pound to US Dollar foreign exchange rates.
- 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	5 - 40 years
Computer hardware and software	3 - 5 years
Furniture and equipment	3 - 10 years
Land improvements	10 - 20 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 as a component of earnings from operations 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	3 - 21 years
Provider contracts	4 - 15 years
Trade names	7 - 20 years
Developed technologies	2 - 7 years

The Company tests for impairment of intangible assets, as well as long-lived assets, whenever events or changes in circumstances indicate that the carrying value of an asset or asset group (hereinafter referred to as "asset group") may not be recoverable by comparing the sum of the estimated undiscounted future cash flows expected to result from use of the asset group and its eventual disposition to the carrying value. Such factors include, but are not limited to, significant changes in membership, state funding, state contracts and provider networks and contracts. If the sum of the estimated undiscounted future cash flows is less than the carrying value, an impairment determination is required. The amount of impairment is calculated by subtracting the fair value of the asset group from the carrying value of the asset group. An impairment charge, if any, is recognized within earnings from operations.

In the first quarter of 2023, and in conjunction with the Company's updated strategic plan, executive leadership realignment and corresponding 2023 divestitures, the Company revised the way it manages the business, evaluates performance and allocates resources, resulting in an updated segment structure comprised of (1) a Medicaid segment, (2) a Medicare segment, (3) a Commercial segment and (4) an Other segment. As a result of these changes, the Company reassigned goodwill to the impacted reporting units using a relative fair value allocation approach.

The Company tests goodwill for impairment using a fair value approach. The Company is required to test for impairment at least annually, absent a triggering event, which could include a significant decline in operating performance that would require an impairment assessment. Absent any impairment indicators, the Company performs its goodwill impairment testing during the fourth quarter of each year. The Company recognizes an impairment charge for any amount by which the carrying amount of goodwill exceeds its fair value.

The Company first assesses qualitative factors to determine whether it is necessary to perform the quantitative goodwill impairment test. 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.

If the quantitative test is deemed necessary, the Company determines an appropriate valuation technique to estimate a reporting unit's fair value as of the testing date. The Company utilizes either the income approach or the market approach, whichever is most appropriate for the respective reporting unit. The income approach is based on an internally developed discounted cash flow model that includes assumptions related to future growth rates, discount factors, future tax rates and other various assumptions. The market approach is based on financial multiples of comparable companies derived from current market data. The Company then compares the fair value of the reporting unit calculated using the income approach or market approach with its carrying amount and recognizes an impairment charge for the amount by which the carrying amount exceeds fair value. The impairment charge is limited to the total amount of goodwill allocated to the reporting unit. Changes in economic and operating conditions impacting assumptions used in the Company's analyses could result in goodwill impairment in future periods.

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. In many situations, the claims amounts ultimately settled will 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 or COVID-19, 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 model 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.

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 the Centers for Medicare and Medicaid Services (CMS) for its Medicare product 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 factor, 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 may require it to maintain a minimum health benefits ratio (HBR) 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.

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 its bids. Approximately nine to ten months subsequent to the end of the plan year, or later in the case of the coverage gap discount subsidy, a settlement payment is made between CMS and the Company's plans based on the difference between the prospective payments and actual claims experience.

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. The Company recognizes revenue related to administrative services under the TRICARE government-sponsored Managed Care Support Contract for the DoD's TRICARE program on a straight-line basis over the option period, when the fees become fixed and determinable. The TRICARE contract includes various performance-based measures. For each of the measures, an estimate of the amount that has been earned is made at each interim date, and revenue is recognized accordingly.

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, 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 medical loss ratio (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

Additionally, the ACA established a minimum MLR for 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. The Company is engaged in active discussions with the government regarding recovery for CSR payments for benefit years 2018 and beyond.

Premium and Trade Receivables and Unearned Revenue

Premium and service revenues collected in advance 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.

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

	Year Ended December 31,		
	2023	2022	2021
Balance, January 1	\$ 130	\$ 139	\$ 243
Amounts charged to expense	58	70	62
Recoveries	—	—	(43)
Write-offs of uncollectible receivables	(68)	(79)	(123)
Balance, December 31	<u>\$ 120</u>	<u>\$ 130</u>	<u>\$ 139</u>

Significant Customers

The Company receives the majority of its revenues under contracts or subcontracts with state Medicaid managed care programs. Customers where the aggregate annual contract revenues exceeded 10% of total annual revenues included the state of New York, where the percentage of the Company's total revenue was 10% for the year ended December 31, 2021. None of the Company's customers exceeded 10% of total annual revenues for the years ended December 31, 2023 and 2022.

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 related to stock compensation are presented as a cash inflow from operating activities. The Company accounts for forfeitures when they occur.

Foreign Currency Translation

The Company is exposed to foreign currency exchange risk through its international subsidiaries whose functional currencies have historically included the Euro and Great British Pound. The assets and liabilities of the Company's subsidiaries are translated into United States dollars at the balance sheet date. The Company translates its proportionate share of earnings using average rates during the year. The resulting foreign currency translation adjustments are recorded as a separate component of accumulated other comprehensive earnings (loss).

Recent Accounting Guidance Not Yet Adopted

In November 2023, the Financial Accounting Standards Board (FASB) issued an Accounting Standards Update (ASU) which is intended to improve reportable segment disclosure requirements, primarily through enhanced disclosures about significant expenses. The amendments will require public entities to disclose significant segment expenses that are regularly provided to the chief operating decision maker and included within segment profit and loss. The new standard is effective for annual periods beginning after December 15, 2023, and for interim periods within fiscal years beginning after December 15, 2024. The Company is currently evaluating the effect of the new disclosure requirements.

In December 2023, the FASB issued an ASU which includes amendments that further enhance income tax disclosures, primarily through standardization and disaggregation of rate reconciliation categories and income taxes paid by jurisdiction. The new standard is effective for annual periods beginning after December 15, 2024. The Company is currently evaluating the effect of the new disclosure requirements.

3. Acquisitions and Divestitures

Magellan Acquisition

On January 4, 2022, the Company acquired all of the issued and outstanding shares of Magellan. Total consideration for the acquisition was \$2,491 million, consisting of \$2,431 million in cash and \$60 million related to the fair value of replacement equity awards associated with pre-combination service. The purchase price has been adjusted to reflect the net effective settlement of preexisting relationships between the Company and Magellan of \$70 million. The Company recognized \$106 million of acquisition related expenses related to Magellan for the year ended December 31, 2022.

The Magellan acquisition was accounted for as a business combination using the acquisition method of accounting that requires assets acquired and liabilities assumed to be recognized at fair value as of the acquisition date. The valuation of all assets acquired and liabilities assumed was finalized in the fourth quarter of 2022.

The Company's allocation of the fair value of assets acquired and liabilities assumed as of the acquisition date of January 4, 2022 is as follows (\$ in millions):

Assets acquired and liabilities assumed	
Cash and cash equivalents	\$ 995
Premium and related receivables	791
Short-term investments	144
Other current assets	145
Long-term investments	43
Restricted deposits	7
Property, software and equipment	72
Intangible assets ⁽¹⁾	889
Other long-term assets	50
Total assets acquired	3,136
Medical claims liability	194
Accounts payable and accrued expenses	495
Return of premium payable	53
Unearned revenue	8
Current portion of long-term debt	5
Long-term debt ⁽²⁾	542
Deferred tax liabilities ⁽³⁾	157
Other long-term liabilities	64
Total liabilities assumed	1,518
Mezzanine equity	32
Total identifiable net assets	1,586
Goodwill ⁽⁴⁾	905
Total assets acquired and liabilities assumed	\$ 2,491

Significant fair value adjustments are noted as follows:

⁽¹⁾ The identifiable intangible assets acquired are to be measured at fair value as of the completion of the acquisition. The fair value of intangible assets is determined primarily using variations of the income approach, which is based on the present value of the future after-tax cash flows attributable to each identified intangible asset. Other valuation methods, including the market approach and cost approach, were also considered in estimating the fair value. The identifiable intangible assets include purchased contract rights, provider contracts, developed technologies and trade names. The Company has estimated the fair value of intangible assets to be \$889 million with a weighted average life of 12 years.

The fair values and weighted average useful lives for identifiable intangible assets acquired are as follows (\$ in millions):

	<u>Fair Value</u>	<u>Weighted Average Useful Life in Years</u>
Purchased contract rights	\$ 581	13
Provider contracts	120	15
Developed technologies	101	5
Trade names	87	17
Total intangible assets acquired	<u>\$ 889</u>	<u>12</u>

(2) Debt is required to be measured at fair value under the acquisition method of accounting. The fair value of Magellan's Senior Notes and Credit Agreement assumed in the acquisition was \$535 million. In January 2022, the Company paid off Magellan's debt acquired in the transaction using Magellan's cash on hand.

(3) The deferred tax liabilities are presented net of \$102 million of deferred tax assets.

(4) The acquisition resulted in \$905 million of goodwill primarily related to synergies expected from the acquisition and the assembled workforce of Magellan. All of the goodwill was assigned to the Other segment. The majority of the goodwill is not deductible for income tax purposes.

PANTHERx Rare Divestiture

On July 14, 2022, the Company completed the divestiture of PANTHERx for \$1,373 million. The Company recognized a gain of \$490 million, or \$382 million after-tax, which is included in investment and other income in the Consolidated Statements of Operations.

Spanish and Central European Divestiture

On November 16, 2022, the Company completed the divestiture of its ownership stakes in its Spanish and Central European businesses, including Ribera Salud, Torrejón Salud and Pro Diagnostics Group.

During 2022, the Company recorded an impairment charge primarily related to intangible assets and goodwill associated with the divestiture of \$163 million, or \$140 million after-tax. In 2023, the Company recognized an additional loss on sale of \$13 million, or \$10 million after-tax, which is included in investment and other income in the Consolidated Statements of Operations.

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 divestiture of \$22 million, or \$10 million after-tax, due to the finalization of working capital adjustments.

Magellan Specialty Health Divestiture

On November 17, 2022, the Company signed a definitive agreement to divest Magellan Specialty Health. As of December 31, 2022, the assets and liabilities of Magellan Specialty Health were considered held for sale, resulting in \$645 million of assets held for sale in other current assets and \$87 million of liabilities held for sale in accounts payable and accrued expenses in the Consolidated Balance Sheets. The majority of the of held for sale assets were previously reported as goodwill and intangible assets.

On January 20, 2023, the Company completed the divestiture for \$646 million in cash and stock, including an estimated working capital adjustment, and recognized a pre-tax gain of \$79 million. The stock consideration was subsequently sold in April 2023 for cash proceeds of \$245 million. The Company could also receive up to an additional \$150 million in cash and stock in 2024 based on certain 2023 performance metrics. The Company will recognize the appropriate amount of contingent consideration related to the \$150 million when realized or realizable.

Centurion Divestiture

On January 10, 2023, the Company signed and closed a definitive agreement to divest Centurion. As of December 31, 2022, the assets and liabilities of Centurion were considered held for sale resulting in \$236 million of assets held for sale in other current assets and \$198 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 premium and trade receivables. The majority of the liabilities were previously reported as medical claims liability and accounts payable and accrued liabilities.

During 2022, the Company recorded an impairment charge related to goodwill and other current assets associated with the divestiture of \$259 million, or \$181 million after-tax. During 2023, the Company recognized a gain of \$15 million, or \$10 million after-tax, reflecting additional proceeds for contingent consideration, partially offset by net working capital adjustments. The gain is included in investment and other income in the Consolidated Statements of Operations.

HealthSmart Divestiture

On November 1, 2022, the Company signed a definitive agreement to divest HealthSmart. The divestiture was completed on January 5, 2023. As of December 31, 2022, the assets and liabilities of HealthSmart were considered held for sale resulting in \$66 million of assets held for sale in other current assets and \$34 million of liabilities held for sale in accounts payable and accrued expenses in the Consolidated Balance Sheets. The majority of the held for sale assets were previously reported as cash and cash equivalents, premium and trade receivables and goodwill.

During 2022, the Company recorded an impairment charge related to goodwill associated with the divestiture of \$36 million, or \$27 million after-tax.

Apixio Divestiture

On June 13, 2023, the Company completed the divestiture of its majority stake in Apixio. The Company recognized a pre-tax gain of \$93 million, or \$67 million after-tax, 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 is included in the Other segment. As of December 31, 2023, the assets and liabilities of Circle Health were considered held for sale resulting in \$3,897 million of assets held for sale in other current assets and \$3,094 million of liabilities held for sale in accounts payable and accrued expenses in the Consolidated Balance Sheets. The majority of the held for sale assets were previously reported as other long-term assets, goodwill and property, software and equipment. The majority of the liabilities were previously reported as debt and other long-term liabilities.

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 expires 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. The fair value of the swap agreement as of December 31, 2023 was \$13 million, which was recorded in accounts payable and accrued expenses in the Consolidated Balance Sheets.

On January 12, 2024, the Company completed the divestiture for \$931 million and settled the foreign currency swap. The Company expects to realize a net tax benefit of \$50 million in 2024 on the loss recognized on the divestiture.

Operose Health Group Divestiture

In November 2023, the Company signed a definitive agreement to sell Operose Health and completed the divestiture on December 28, 2023. During 2023, the Company recorded impairment charges to Operose Health primarily related to goodwill, intangible assets and property, software and equipment of \$140 million, or \$128 million after-tax based on market indicators of fair value.

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, 2023				December 31, 2022			
	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	\$ 403	\$ —	\$ (8)	\$ 395	\$ 695	\$ —	\$ (16)	\$ 679
Corporate securities	9,984	78	(461)	9,601	10,127	12	(778)	9,361
Restricted certificates of deposit	4	—	—	4	4	—	—	4
Restricted cash equivalents	259	—	—	259	256	—	—	256
Short-term time deposits	746	—	—	746	204	—	—	204
Municipal securities	4,135	21	(171)	3,985	4,055	6	(280)	3,781
Asset-backed securities	1,665	8	(35)	1,638	1,396	—	(70)	1,326
Residential mortgage-backed securities	1,503	7	(103)	1,407	1,165	2	(121)	1,046
Commercial mortgage-backed securities	1,149	5	(82)	1,072	961	—	(99)	862
Equity securities	17	—	—	17	17	—	—	17
Private equity investments	833	—	—	833	529	—	—	529
Life insurance contracts	174	—	—	174	157	—	—	157
Total	<u>\$ 20,872</u>	<u>\$ 119</u>	<u>\$ (860)</u>	<u>\$ 20,131</u>	<u>\$ 19,566</u>	<u>\$ 20</u>	<u>\$ (1,364)</u>	<u>\$ 18,222</u>

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. 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, 2023, 99% of the Company's investments in rated securities carry an investment grade rating by nationally recognized statistical rating organizations. At December 31, 2023, 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 \$153 million and \$132 million at December 31, 2023 and 2022, 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 4 years at December 31, 2023.

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, 2023				December 31, 2022			
	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	\$ —	\$ 79	\$ (8)	\$ 232	\$ (5)	\$ 342	\$ (11)	\$ 184
Corporate securities	(6)	658	(455)	6,260	(340)	5,368	(438)	3,400
Municipal securities	(4)	553	(167)	2,237	(142)	2,437	(138)	995
Asset-backed securities	(2)	197	(33)	855	(29)	786	(41)	486
Residential mortgage-backed securities	(2)	153	(101)	814	(55)	629	(66)	352
Commercial mortgage-backed securities	(2)	114	(80)	754	(49)	513	(50)	330
Short-term time deposits	—	31	—	—	—	—	—	—
Total	\$ (16)	\$ 1,785	\$ (844)	\$ 11,152	\$ (620)	\$ 10,075	\$ (744)	\$ 5,747

As of December 31, 2023, the gross unrealized losses were generated from 5,247 positions out of a total of 6,661 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, 2023				December 31, 2022			
	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	\$ 2,308	\$ 2,284	\$ 566	\$ 564	\$ 2,207	\$ 2,179	\$ 534	\$ 532
One year through five years	7,738	7,431	527	504	7,651	7,147	524	490
Five years through ten years	3,905	3,735	298	283	4,066	3,613	224	195
Greater than ten years	155	154	34	35	135	129	—	—
Asset-backed securities	4,317	4,117	—	—	3,522	3,234	—	—
Total	\$ 18,423	\$ 17,721	\$ 1,425	\$ 1,386	\$ 17,581	\$ 16,302	\$ 1,282	\$ 1,217

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, 2023, 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	\$ 17,193	\$ —	\$ —	\$ 17,193
Investments:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	\$ 62	\$ —	\$ —	\$ 62
Corporate securities	—	9,564	—	9,564
Municipal securities	—	3,232	—	3,232
Short-term time deposits	—	746	—	746
Asset-backed securities	—	1,638	—	1,638
Residential mortgage-backed securities	—	1,407	—	1,407
Commercial mortgage-backed securities	—	1,072	—	1,072
Equity securities	15	2	—	17
Total investments	\$ 77	\$ 17,661	\$ —	\$ 17,738
Restricted deposits:				
Cash and cash equivalents	\$ 259	\$ —	\$ —	\$ 259
U.S. Treasury securities and obligations of U.S. government corporations and agencies	333	—	—	333
Corporate securities	—	37	—	37
Certificates of deposit	—	4	—	4
Municipal securities	—	753	—	753
Total restricted deposits	\$ 592	\$ 794	\$ —	\$ 1,386
Total assets at fair value	\$ 17,862	\$ 18,455	\$ —	\$ 36,317
Liabilities				
Accounts payable and accrued expenses:				
Foreign currency swap agreement	\$ —	\$ 13	\$ —	\$ 13
Total liabilities at fair value	\$ —	\$ 13	\$ —	\$ 13

The following table summarizes fair value measurements by level at December 31, 2022, 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	\$ 12,074	\$ —	\$ —	\$ 12,074
Investments:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	\$ 366	\$ 5	\$ —	\$ 371
Corporate securities	—	9,328	—	9,328
Municipal securities	—	3,165	—	3,165
Short-term time deposits	—	204	—	204
Asset-backed securities	—	1,326	—	1,326
Residential mortgage-backed securities	—	1,046	—	1,046
Commercial mortgage-backed securities	—	862	—	862
Equity securities	15	2	—	17
Total investments	\$ 381	\$ 15,938	\$ —	\$ 16,319
Restricted deposits:				
Cash and cash equivalents	\$ 256	\$ —	\$ —	\$ 256
U.S. Treasury securities and obligations of U.S. government corporations and agencies	308	—	—	308
Corporate securities	—	33	—	33
Certificates of deposit	—	4	—	4
Municipal securities	—	616	—	616
Total restricted deposits	\$ 564	\$ 653	\$ —	\$ 1,217
Total assets at fair value	\$ 13,019	\$ 16,591	\$ —	\$ 29,610

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 \$1,007 million and \$686 million as of December 31, 2023 and December 31, 2022, respectively.

6. Property, Software and Equipment

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

	December 31, 2023	December 31, 2022
Computer software	\$ 2,631	\$ 2,224
Computer hardware	542	604
Buildings	534	659
Furniture and office equipment	304	366
Leasehold improvements	252	467
Land	156	178
Property, software and equipment, at cost	4,419	4,498
Less: accumulated depreciation	(2,400)	(2,066)
Property, software and equipment, net	\$ 2,019	\$ 2,432

Depreciation expense for the years ended December 31, 2023, 2022 and 2021 was \$575 million, \$614 million and \$565 million, respectively.

The decrease in property, software and equipment in 2023 was primarily driven by divestiture related activity as discussed in Note 3. *Acquisitions and Divestitures*. Specifically, as of December 31, 2023, Circle Health was considered held for sale, and accordingly, the associated property, software and equipment of \$447 million was reclassified to other current assets.

During the second quarter of 2022, in connection with the adoption of a more modern, flexible work environment, the Company undertook a real estate optimization initiative to evaluate future real estate needs and downsize its real estate footprint for owned and leased properties. As a result of this evaluation, the Company substantially changed the use or abandoned various properties and assessed for impairment. The Company engaged a third-party real estate specialist to determine the fair value of its owned properties. The valuation primarily considered comparable properties in each market as well as future cash flows.

As a result of the optimization, the Company recognized impairment charges related to owned real estate and fixed assets related to leased real estate of \$57 million and \$1,050 million for the years ended December 31, 2023 and 2022, respectively. The remainder of the \$97 million and \$1,627 million impairment charges for the years ended December 31, 2023 and 2022, respectively, relate to right-of-use (ROU) asset impairments, which is included within other long-term assets in the Consolidated Balance Sheets, refer to Note 11. *Leases*.

7. Goodwill and Intangible Assets

As discussed in Note 1. *Organization and Operations*, in the first quarter of 2023 the Company updated its segment structure. Prior year information has been adjusted to reflect the change in segment reporting.

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

	Medicaid	Medicare	Commercial	Other	Consolidated Total
Balance, December 31, 2021	\$ 10,194	\$ 1,592	\$ 5,424	\$ 2,561	\$ 19,771
Acquisition and purchase accounting adjustments	—	—	—	1,077	1,077
Divestitures	—	—	—	(1,533)	(1,533)
Reallocation	4	—	—	(4)	—
Impairments	—	—	—	(370)	(370)
Translation impact	—	—	—	(133)	(133)
Balance, December 31, 2022	\$ 10,198	\$ 1,592	\$ 5,424	\$ 1,598	\$ 18,812
Divestitures	—	—	—	(912)	(912)
Impairments	—	—	—	(392)	(392)
Translation impact	—	—	—	50	50
Balance, December 31, 2023	\$ 10,198	\$ 1,592	\$ 5,424	\$ 344	\$ 17,558

In 2023, divestiture related activity in goodwill included the completed divestiture of Apixio as well as \$760 million of goodwill reclassified to other current assets associated with the divestiture of Circle Health, which was considered held for sale as of December 31, 2023. In 2022, divestiture related activity in goodwill included the completed divestitures of PANTHERx and Magellan Rx, as well as goodwill reclassified to other current assets associated with the divestiture of Magellan Specialty Health, which was considered held for sale as of December 31, 2022. The acquired goodwill in 2022 represents goodwill associated with the Magellan acquisition.

The Company's Other segment impairments in 2023 were driven by the Circle Health and Operose Health divestitures. The Company's Other segment impairments in 2022 were driven by the impairment of the Federal Services business, which included \$216 million of goodwill, in conjunction with the December 2022 announcement from the DoD that the Company was not awarded a TRICARE Managed Care Support Contract, as well as the divestiture of the Spanish and Central European businesses.

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

			Weighted Average Useful Life in Years	
	2023	2022	2023	2022
Purchased contract rights and customer relationships	\$ 7,845	\$ 7,850	13.5	13.4
Trade names	943	983	15.6	15.4
Provider contracts	612	612	14.0	14.0
Developed technologies	298	390	4.4	5.3
Intangible assets	9,698	9,835	13.4	13.4
Less: accumulated amortization				
Purchased contract rights and customer relationships	(2,768)	(2,193)		
Trade names	(320)	(263)		
Provider contracts	(227)	(183)		
Developed technologies	(282)	(285)		
Total accumulated amortization	(3,597)	(2,924)		
Intangible assets, net	\$ 6,101	\$ 6,911		

The decrease in intangible assets in 2023 was primarily driven by divestiture related activity, which included related impairments, during the year as discussed with goodwill above and in Note 3. *Acquisitions and Divestitures*.

Amortization expense was \$718 million, \$817 million and \$770 million for the years ended December 31, 2023, 2022 and 2021, respectively. Estimated total amortization expense related to the December 31, 2023 intangible assets for each of the five succeeding fiscal years is as follows (\$ in millions):

	Estimated Total Amortization Expense
2024	\$ 692
2025	690
2026	673
2027	663
2028	662

8. Medical Claims Liability

As discussed in Note 1. *Organization and Operations*, in the first quarter of 2023 the Company updated its segment structure. Prior year information has been adjusted to reflect the change in segment reporting.

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

The following table summarizes the change in medical claims liability for the year ended December 31, 2022 (\$ in millions):

	Medicaid	Medicare	Commercial	Other	Consolidated Total
Balance, January 1, 2022	\$ 9,845	\$ 2,286	\$ 2,014	\$ 98	\$ 14,243
Less: Reinsurance recoverables	23	—	—	—	23
Balance, January 1, 2022, net	9,822	2,286	2,014	98	14,220
Acquisitions and divestitures	—	—	—	105	105
Incurred related to:					
Current year	76,344	19,474	14,296	2,782	112,896
Prior years	(1,046)	(102)	(204)	(15)	(1,367)
Total incurred	75,298	19,372	14,092	2,767	111,529
Paid related to:					
Current year	66,221	16,275	12,556	2,747	97,799
Prior years	7,653	1,952	1,648	83	11,336
Total paid	73,874	18,227	14,204	2,830	109,135
Balance, December 31, 2022, net	11,246	3,431	1,902	140	16,719
Plus: Reinsurance recoverables	7	—	19	—	26
Balance, December 31, 2022	\$ 11,253	\$ 3,431	\$ 1,921	\$ 140	\$ 16,745

The following table summarizes the change in medical claims liability for the year ended December 31, 2021 (\$ in millions):

	<u>Medicaid</u>	<u>Medicare</u>	<u>Commercial</u>	<u>Other</u>	<u>Consolidated Total</u>
Balance, January 1, 2021	\$ 8,567	\$ 2,012	\$ 1,801	\$ 58	\$ 12,438
Less: Reinsurance recoverables	23	—	—	—	23
Balance, January 1, 2021, net	8,544	2,012	1,801	58	12,415
Incurred related to:					
Current year	68,720	15,388	14,706	1,571	100,385
Prior years	(1,616)	(142)	(17)	(8)	(1,783)
Total incurred	67,104	15,246	14,689	1,563	98,602
Paid related to:					
Current year	59,839	13,275	12,839	1,474	87,427
Prior years	5,987	1,697	1,637	49	9,370
Total paid	65,826	14,972	14,476	1,523	96,797
Balance, December 31, 2021, net	9,822	2,286	2,014	98	14,220
Plus: Reinsurance recoverables	23	—	—	—	23
Balance, December 31, 2021	<u>\$ 9,845</u>	<u>\$ 2,286</u>	<u>\$ 2,014</u>	<u>\$ 98</u>	<u>\$ 14,243</u>

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 and continued integration activities. Additionally, as a result of minimum HBR and other return of premium programs, the Company recorded approximately \$382 million, \$198 million and \$492 million of the "Incurred related to: Prior years" as a reduction to premium revenues in 2023, 2022 and 2021, 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 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.

Information about incurred and paid claims development as of December 31, 2023 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, 2023 is as follows (\$ in millions):

Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance					
For the Year Ended December 31,					
Claim Year		2021 (unaudited)		2022 (unaudited)	2023
2021	\$	100,385	\$	99,087	\$ 99,077
2022				112,896	110,870
2023					120,680
				Total incurred claims	\$ 330,627
Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance					
For the Year Ended December 31,					
Claim Year		2021 (unaudited)		2022 (unaudited)	2023
2021	\$	87,427	\$	98,024	\$ 98,645
2022				97,799	109,680
2023					104,725
				Total payment of incurred claims	313,050
				All outstanding liabilities prior to 2021, net of reinsurance	124
				Medical claims liability, net of reinsurance	\$ 17,701

Incurred and paid claims development for the Medicaid segment as of December 31, 2023 is as follows (\$ in millions):

Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance					
For the Year Ended December 31,					
Claim Year		2021 (unaudited)		2022 (unaudited)	2023
2021	\$	68,720	\$	67,682	\$ 67,628
2022				76,344	74,861
2023					79,747
				Total incurred claims	\$ 222,236
Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance					
For the Year Ended December 31,					
Claim Year		2021 (unaudited)		2022 (unaudited)	2023
2021	\$	59,838	\$	66,903	\$ 67,436
2022				66,220	74,125
2023					69,904
				Total payment of incurred claims	211,465
				All outstanding liabilities prior to 2021, net of reinsurance	38
				Medical claims liability, net of reinsurance	\$ 10,809

Incurred and paid claims development for the Medicare segment as of December 31, 2023 is as follows (\$ in millions):

Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance					
For the Year Ended December 31,					
Claim Year	2021 (unaudited)		2022 (unaudited)		2023
2021	\$	15,388	\$	15,330	\$ 15,337
2022				19,475	19,124
2023					19,487
			Total incurred claims	\$	53,948
Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance					
For the Year Ended December 31,					
Claim Year	2021 (unaudited)		2022 (unaudited)		2023
2021	\$	13,275	\$	15,178	\$ 15,187
2022				16,276	18,818
2023					16,631
			Total payment of incurred claims		50,636
			All outstanding liabilities prior to 2021, net of reinsurance		50
			Medical claims liability, net of reinsurance	\$	3,362

Incurred and paid claims development for the Commercial segment as of December 31, 2023 is as follows (\$ in millions):

Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance					
For the Year Ended December 31,					
Claim Year	2021 (unaudited)		2022 (unaudited)		2023
2021	\$	14,706	\$	14,519	\$ 14,556
2022				14,296	14,110
2023					19,966
			Total incurred claims	\$	48,632
Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance					
For the Year Ended December 31,					
Claim Year	2021 (unaudited)		2022 (unaudited)		2023
2021	\$	12,840	\$	14,387	\$ 14,466
2022				12,556	13,963
2023					16,823
			Total payment of incurred claims		45,252
			All outstanding liabilities prior to 2021, net of reinsurance		36
			Medical claims liability, net of reinsurance	\$	3,416

Incurred and paid claims development for the Other segment as of December 31, 2023 is as follows (\$ in millions):

Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance					
For the Year Ended December 31,					
Claim Year	2021 (unaudited)		2022 (unaudited)		2023
2021	\$	1,571	\$	1,556	\$ 1,556
2022				2,781	2,775
2023					1,480
			Total incurred claims	\$	5,811

Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance					
For the Year Ended December 31,					
Claim Year	2021 (unaudited)		2022 (unaudited)		2023
2021	\$	1,474	\$	1,556	\$ 1,556
2022				2,747	2,774
2023					1,367
			Total payment of incurred claims		5,697
			All outstanding liabilities prior to 2021, net of reinsurance		—
			Medical claims liability, net of reinsurance	\$	114

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, 2023 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, 2023		
	Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance	Total IBNR Plus Expected Development on Reported Claims	Cumulative Paid Claims
2021	\$ 99,077	\$ 3	624.0
2022	110,870	429	637.5
2023	120,680	11,135	599.3

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

	December 31, 2023		
	Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance	Total IBNR Plus Expected Development on Reported Claims	Cumulative Paid Claims
2021	\$ 67,628	\$ 3	376.6
2022	74,861	306	370.6
2023	79,747	6,859	327.3

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

	December 31, 2023		
	Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance	Total IBNR Plus Expected Development on Reported Claims	Cumulative Paid Claims
2021	\$ 15,337	\$ —	185.9
2022	19,124	86	204.7
2023	19,487	1,783	198.4

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

	December 31, 2023		
	Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance	Total IBNR Plus Expected Development on Reported Claims	Cumulative Paid Claims
2021	\$ 14,556	\$ —	60.9
2022	14,110	37	57.4
2023	19,966	2,393	69.8

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

	December 31, 2023		
	Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance	Total IBNR Plus Expected Development on Reported Claims	Cumulative Paid Claims
2021	\$ 1,556	\$ —	0.6
2022	2,775	—	4.8
2023	1,480	100	3.8

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, 2023	December 31, 2022
Risk adjustment receivable	\$ 893	\$ 838
Risk adjustment payable	(2,553)	(780)
Minimum medical loss ratio	(164)	(103)
Cost sharing reduction payable	(114)	(99)

In June 2023, CMS announced the final risk adjustment transfers for the 2022 benefit year. As a result of and subsequent to the announcement, the Company increased its risk adjustment net receivables by \$306 million from December 31, 2022. After consideration of minimum MLR and other related impacts, the net pre-tax benefit recognized was approximately \$260 million for the year ended December 31, 2023.

10. Debt

Debt consists of the following (\$ in millions):

	December 31, 2023	December 31, 2022
\$2,500 million 4.25% Senior Notes, due December 15, 2027	\$ 2,395	\$ 2,393
\$2,300 million 2.45% Senior Notes, due July 15, 2028	2,303	2,303
\$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	15,675	15,673
Term Loan Facility	2,115	2,183
Revolving Credit Agreement	150	58
Finance leases and other	11	253
Debt issuance costs	(122)	(147)
Total debt	17,829	18,020
Less: current portion	(119)	(82)
Long-term debt	\$ 17,710	\$ 17,938

Senior Notes

In connection with the Magellan acquisition in January 2022, the Company paid off Magellan's debt of \$535 million acquired in the transaction using Magellan's cash on hand. Specifically, the Company redeemed Magellan's existing outstanding 4.4% Senior Notes due 2024 and paid off the existing Credit Agreement. The Company recognized an immaterial net pre-tax gain on extinguishment including related fees and expenses and the write-off of the unamortized premium.

During 2022, the Company utilized a portion of the proceeds from the PANTHERx divestiture to repurchase \$95 million of its par value Senior Notes due 2027 and \$223 million of its par value Senior Notes due 2029 through the Company's senior note debt repurchase program. The Company recognized a \$14 million gain on the redemptions of the notes.

The indentures governing the senior notes listed in the table above contain restrictive covenants of Centene Corporation. At December 31, 2023, the Company was in compliance with all covenants.

Circle Health Debt Refinancing

In May 2022, the Company refinanced certain debt agreements for its Circle Health subsidiary with a new £250 million credit facility maturing in May 2025. The Company recognized a \$13 million pre-tax gain on the extinguishment of the existing debt. As of December 31, 2023, £150 million was drawn on the facility, and was included in accounts payable and accrued expenses in the Consolidated Balance Sheets as a liability held for sale. The facility is guaranteed by the Company and has similar borrowing rates and covenants to the Company's Revolving Credit Agreement, except it uses the Sterling Overnight Index Average (SONIA) as the reference rate for the interest rate payable. In January 2024, the Company completed the divestiture of Circle Health and terminated the credit facility.

Revolving Credit Facility and Term Loan Credit Facility

In May 2023, the Company entered into a first amendment to the Company's Fourth Amended and Restated Credit Agreement. The amendment removed and replaced the interest rate benchmark based on the London Interbank Offered Rate (LIBOR) and related LIBOR-based mechanics applicable to U.S. dollar borrowings under the Amended and Restated Credit Agreement with an interest rate benchmark based on the Secured Overnight Financing Rate (SOFR) (including a customary credit spread adjustment) and related SOFR-based mechanics. Additionally, the amendment removed certain provisions which required the Company to make certain mandatory prepayments of the Term Loan Facility.

The Company has (i) unsecured \$2,000 million multi-currency revolving credit facility (the Revolving Credit Facility), which includes a \$300 million sub-limit for letters of credit and a \$200 million sub-limit for swingline loans and (ii) a \$2,200 million unsecured delayed-draw term loan facility (the Term Loan Facility, and together with the Revolving Credit Facility, the Company Credit Facility). Borrowings under the Revolving Credit Facility bear interest, at the Company's option, at SOFR, SONIA, Euro Interbank Offered Rate (EURIBOR), Swiss Average Rate Overnight (SARON), Tokyo Interbank Offered Rate (TIBOR), Canadian Dollar Offered Rate (CDOR), Bank Buying Rate (BBR) or base rates plus, in each case, an applicable margin between 1.50% to 1.125%, based on the total debt to EBITDA ratio and type of borrowing. Borrowings under the Term Loan Facility bear interest, at the Company's option, at SOFR or base rates plus, in each case, an applicable margin based on the total debt to EBITDA ratio. The Company has an uncommitted option to increase its Company Credit Facility by an additional \$500 million plus certain additional amounts based on its total debt to EBITDA ratio. The Term Loan Facility includes scheduled amortization payments equal to 0% for the first year following closing, 2.5% for the second year following closing and 5% thereafter until maturity.

The Company Credit Facility contains financial covenants including maintenance of a minimum fixed charge coverage ratio and a restriction on the Company's maximum total debt to EBITDA ratio not to exceed 4.0 to 1.0. It also contains certain non-financial covenants including: limitations on incurrence of additional indebtedness; restrictions on incurrence of liens; restrictions on dividends and other restricted payments; restrictions on investments, mergers, consolidations and asset sales; and limitations on transactions with affiliates. As of December 31, 2023, the Company was in compliance with all financial and non-financial covenants under the Company Credit Facility.

As of December 31, 2023, the Company had \$150 million of borrowings outstanding under the Revolving Credit Facility, with an interest rate of the base rate plus 0.25% margin.

The Revolving Credit Facility and the Term Loan Facility will mature on August 16, 2026.

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, 2022, the Company repurchased \$318 million of its par value senior notes, as described above, for \$300 million. No repurchases were made during the year ended December 31, 2023. As of December 31, 2023, there was \$700 million available under the senior note debt repurchase program.

Letters of Credit & Surety Bonds

The Company had outstanding letters of credit of \$152 million as of December 31, 2023, which were not part of the Revolving Credit Facility. The letters of credit bore interest at 0.7% as of December 31, 2023. The Company had outstanding surety bonds of \$856 million as of December 31, 2023.

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

	Aggregate Maturities
2024	\$ 119
2025	113
2026	2,048
2027	2,405
2028	2,300
Thereafter	10,977
Total	<u>\$ 17,962</u>

The fair value of outstanding debt was approximately \$16,322 million and \$15,791 million at December 31, 2023 and 2022, respectively.

11. Leases

The Company records 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 \$349 million and \$429 million during the years ended December 31, 2023 and 2022, 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):

	<u>December 31, 2023</u>	<u>December 31, 2022</u>
Assets		
ROU assets (recorded within other long-term assets)	\$ 396	\$ 2,554
Liabilities		
Short-term (recorded within accounts payable and accrued expenses)	\$ 168	\$ 180
Long-term (recorded within other long-term liabilities)	880	3,133
Total lease liabilities	<u>\$ 1,048</u>	<u>\$ 3,313</u>

The decrease in ROU assets and lease liabilities in 2023 was primarily driven by divestiture related activity as discussed in Note 3. *Acquisitions and Divestitures*. Specifically, as of December 31, 2023, Circle Health was considered held for sale and accordingly the associated ROU assets of \$2,113 million and lease liabilities of \$2,197 million were reclassified to other current assets and accounts payable and accrued expenses, respectively, in the Consolidated Balance Sheets.

Cash paid for amounts included in the measurement of lease liabilities, recorded as operating cash flows in the Consolidated Statements of Cash Flows, was \$378 million and \$440 million during the years ended December 31, 2023 and 2022, respectively. New operating leases commenced resulting in the recognition of ROU assets and lease liabilities of \$40 million and \$60 million during the years ended December 31, 2023 and 2022, respectively. In connection with the acquisition of Magellan in January 2022, the Company acquired \$30 million of ROU assets and lease liabilities. As of December 31, 2023, the Company had additional operating leases that have not yet commenced of \$1 million. These operating leases will commence in 2024 with lease terms of approximately five years.

As part of the real estate optimization initiative as described in Note 6. *Property, Software and Equipment*, the Company vacated and abandoned various domestic leased properties. As a result, the Company assessed the ROU assets for impairment. The Company engaged a third-party real estate specialist to determine the recoverability of the leased properties. The valuation primarily considered comparable leased properties in each market and the assessment of potential future rental income that could be generated by the ROU assets.

As a result of the ongoing real estate optimization initiative, the Company recognized \$40 million and \$577 million of ROU asset impairments for the years ended December 31, 2023 and 2022, respectively. The remainder of the \$97 million and \$1,627 million real estate optimization impairment charges for the years ended December 31, 2023 and 2022, respectively, was related to Property, Software and Equipment, refer to Note 6. *Property, Software and Equipment*.

As of December 31, 2023, the weighted average remaining lease term for the Company was 20.5 years. The average remaining lease term of the Circle Health portfolio is 26.3 years. Excluding Circle Health, the average remaining lease term of the Company's portfolio is 8.1 years. The lease liabilities as of December 31, 2023, reflect a weighted average discount rate of 5.8%, or 3.3% excluding Circle Health.

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

	Lease Payments
2024	\$ 198
2025	174
2026	148
2027	132
2028	112
Thereafter	434
Total lease payments	1,198
Less: imputed interest	(150)
Total lease liabilities	\$ 1,048

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. In 2023, the Company's Board of Directors authorized an increase under the program of \$4,000 million. With these increases, the Company is authorized to repurchase up to \$10,000 million, inclusive of past authorizations. As of December 31, 2023, the Company had a remaining amount of \$5,229 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 2023, 2022 and 2021 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,					
	2023		2022⁽²⁾		2021	
	Shares	Cost	Shares	Cost	Shares	Cost
Share buybacks	22,886	\$ 1,577	35,655	\$ 2,994	2,402	\$ 200
Income tax withholding	828	56	1,213	102	1,379	97
Total share repurchases ⁽¹⁾	23,714	\$ 1,633	36,868	\$ 3,096	3,781	\$ 297

⁽¹⁾ Excludes share repurchase excise tax of \$10 million accrued as of December 31, 2023.

⁽²⁾ Includes 11.6 million shares delivered as part of an accelerated share repurchase (ASR) agreement with a \$1,000 million notional amount. The Company purchased additional shares throughout the year through open market repurchases, including repurchase plans designed to comply with Rule 10b5-1.

Shares repurchased for income tax withholding are shares withheld in connection with employee stock plans to meet applicable tax withholding requirements. These shares are typically included in the Company's treasury stock, except for the vesting of certain shares assumed in connection with the WellCare acquisition in 2021, which were withheld rather than repurchased. Although these shares are not issued, they are treated as common stock repurchases as they reduce the number of shares that would have been issued upon vesting. Shares withheld were 326 thousand shares at an aggregate cost of \$19 million for the year ended December 31, 2021. No shares were withheld under this method in 2022 or 2023.

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, 2023 and 2022, Centene's subsidiaries had aggregate statutory capital and surplus of \$18,117 million and \$16,436 million, respectively, compared with the required minimum aggregate statutory capital and surplus of \$8,267 million and \$7,979 million, respectively. As of December 31, 2023, 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 \$8,267 million in the aggregate.

14. Income Taxes

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

	Year Ended December 31,		
	2023	2022	2021
Current provision			
Federal	\$ 833	\$ 1,144	\$ 507
State and local	132	261	114
International	1	4	7
Total current provision	966	1,409	628
Deferred provision	(67)	(649)	(151)
Total income tax expense	<u>\$ 899</u>	<u>\$ 760</u>	<u>\$ 477</u>

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

	Year Ended December 31,		
	2023	2022	2021
Earnings before income tax expense	\$ 3,598	\$ 1,962	\$ 1,813
Loss (earnings) attributable to flow through noncontrolling interest	3	(6)	2
Earnings less noncontrolling interest before income tax expense	3,601	1,956	1,815
Tax provision at the U.S. federal statutory rate	756	411	381
State income taxes, net of federal income tax benefit	75	50	63
Nondeductible compensation	38	49	40
Nondeductible PBM legal settlement	—	(5)	78
Nontaxable divestiture (gains) losses	(4)	111	(95)
Deferred taxes for investments in subsidiaries	3	84	—
Excess tax benefit on stock awards	(59)	(13)	(3)
Valuation allowance	26	(17)	29
Nondeductible goodwill	77	69	—
Other, net	(13)	21	(16)
Income tax expense	<u>\$ 899</u>	<u>\$ 760</u>	<u>\$ 477</u>

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

	December 31, 2023	December 31, 2022
Deferred tax assets:		
Medical claims liability	\$ 217	\$ 132
Nondeductible liabilities	111	202
Net operating loss and tax credit carryforwards	71	341
Compensation accruals	113	96
Premium and trade receivables	94	91
Operating lease liability	269	397
Unrealized loss	179	320
Software development costs	193	209
Other	92	85
Deferred tax assets	<u>1,339</u>	<u>1,873</u>
Valuation allowance	(82)	(205)
Net deferred tax assets	<u>\$ 1,257</u>	<u>\$ 1,668</u>
Deferred tax liabilities:		
Goodwill and intangible assets	\$ 1,603	\$ 1,724
Fixed assets	127	111
Right-of-use asset	98	285
Other	70	163
Deferred tax liabilities	<u>1,898</u>	<u>2,283</u>
Net deferred tax liabilities	<u>\$ (641)</u>	<u>\$ (615)</u>

The decrease to the unrealized loss deferred tax asset reflects the change in the fair market value of the Company's investment portfolio. Decreases to deferred taxes for net operating losses, operating lease liabilities and right of use assets are primarily related to balances associated with Circle Health that are included with held for sale assets and liabilities as of December 31, 2023.

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 federal and state net operating loss, federal and state capital loss and tax credit carryforwards. The decrease to the valuation allowance is primarily related to balances associated with Circle Health that are included with held for sale assets and liabilities as of December 31, 2023.

Federal net operating loss and credit carryforwards of \$13 million expire beginning in 2024 through 2043. State net operating loss and tax credit carryforwards of \$41 million expire beginning in 2024 through 2043, while the remaining \$15 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,	
	2023	2022
Gross unrecognized tax benefits, January 1	\$ 410	\$ 355
Gross increases:		
Current year tax positions	19	52
Acquired reserves	—	7
Prior year tax positions	29	20
Gross decreases:		
Settlements	(2)	(17)
Prior year tax positions	(10)	(3)
Statute of limitation lapses	(7)	(4)
Gross unrecognized tax benefits, December 31	<u>\$ 439</u>	<u>\$ 410</u>

As of December 31, 2023, \$314 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 net interest expense and penalties related to uncertain positions of \$18 million and \$23 million for the years ended December 31, 2023 and 2022, respectively. The Company had \$84 million and \$66 million of accrued interest and penalties for uncertain tax positions as of December 31, 2023 and 2022, respectively.

The Company files federal tax returns as well as returns for numerous state and international tax jurisdictions and is engaged in multiple audit proceedings for its state and foreign filings. Generally, no further state or foreign audit activity is expected for years prior to 2015. As of December 31, 2023, the Company's tax returns are under federal examination for the tax years 2014 through 2017, only with respect to Internal Revenue Service (IRS) proposed adjustments relating to the Company's claims to the Domestic Production Activities Deduction for these years. The Company has appealed the IRS adjustments and the appeals process is expected to be completed within the next 12 months. The Company believes it is reasonably possible that its liability for unrecognized tax benefits will decrease by approximately \$124 million within the next 12 months if the Company reaches a satisfactory agreement with the IRS during the appeals process and an additional \$2 million decrease as a result of the expiration of statutes of limitations and projected audit settlements in certain jurisdictions.

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 2023. The plans have 13 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 \$216 million, \$234 million and \$203 million for the years ended December 31, 2023, 2022 and 2021, respectively. The total income tax benefit recognized in the Statements of Operations for stock-based compensation arrangements was \$101 million, \$48 million and \$35 million for the years ended December 31, 2023, 2022 and 2021, respectively.

A summary of the Company's non-vested restricted stock and restricted stock unit shares as of December 31, 2023, and changes during the year ended December 31, 2023, is presented below (shares in thousands):

	<u>Shares</u>	<u>Weighted Average Grant Date Fair Value</u>
Non-vested balance, December 31, 2022	6,573	\$ 74.20
Granted	4,252	63.40
Vested	(2,741)	72.37
Forfeited	(622)	71.24
Non-vested balance, December 31, 2023	<u>7,462</u>	<u>\$ 68.96</u>

The total fair value of restricted stock and restricted stock units vested during the years ended December 31, 2023, 2022 and 2021, was \$185 million, \$298 million and \$264 million, respectively.

As of December 31, 2023, there was \$243 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 1.8 years.

The Company maintains an employee stock purchase plan and issued 607 thousand shares, 449 thousand shares and 516 thousand shares in 2023, 2022 and 2021, 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 \$131 million, \$133 million and \$105 million during the years ended December 31, 2023, 2022 and 2021, respectively.

17. Contingencies

Overview

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 out-of-network claims, compliance with CMS Medicare and Marketplace regulations, including risk adjustment 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, 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 awards of damages, fines, or penalties, which could be substantial, and/or could require changes to the Company's business. 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 of the 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 reserve estimate as described below with respect to claims or potential claims involving services provided by Envolve Pharmacy Solutions, Inc. (Envolve), as the Company's pharmacy benefits management (PBM) subsidiary. 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, including as described below. Except for the discussion 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.

Pharmacy Benefits Management Matters

On March 11, 2021, the State of Ohio filed a civil action against the Company and the Company's subsidiaries, Buckeye Health Plan Community Solutions, Inc. and Envolve, in Franklin County Court of Common Pleas, captioned as Ohio Department of Medicaid, et al. v. Centene Corporation, et al. The complaint alleged breaches of contract with the Ohio Department of Medicaid relating to the provision of PBM services and violations of Ohio law relating to such contracts, including among other things, by (i) seeking payment for services already reimbursed, (ii) not accurately disclosing to the Ohio Department of Medicaid the true cost of the PBM services and (iii) inflating dispensing fees for prescription drugs. The plaintiffs sought an undisclosed sum of money in damages, penalties, and possible termination of the contract with Buckeye Health Plan. The Company has reached a no-fault settlement with the Ohio Attorney General regarding this matter and the complaint was dismissed.

The Company has reached no-fault settlement agreements related to services previously provided by Envolve with the vast majority of states impacted. Such agreements have provided for payment amounts consistent with the initial reserve estimate established in the second quarter of 2021 related to this issue. Additional claims, reviews, or investigations relating to the Company's historical PBM business across products may be brought by other states, the federal government, or shareholder litigants, and there is no guarantee the Company will have the ability to settle such claims with other states within the reserve estimate the Company has recorded and on other acceptable terms, or at all. This matter is subject to many uncertainties, and an adverse outcome in this matter could have an adverse impact on the Company's financial condition, results of operations, and cash flows.

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,		
	2023	2022	2021
Earnings attributable to Centene Corporation	\$ 2,702	\$ 1,202	\$ 1,347
Shares used in computing per share amounts:			
Weighted average number of common shares outstanding	543,319	575,191	582,832
Common stock equivalents (as determined by applying the treasury stock method)	2,385	6,849	7,684
Weighted average number of common shares and potential dilutive common shares outstanding	<u>545,704</u>	<u>582,040</u>	<u>590,516</u>
Net earnings per common share attributable to Centene Corporation:			
Basic earnings per common share	\$ 4.97	\$ 2.09	\$ 2.31
Diluted earnings per common share	\$ 4.95	\$ 2.07	\$ 2.28

The calculation of diluted earnings per common share for 2023, 2022 and 2021 excludes the impact of 376 thousand shares, 187 thousand shares and 44 thousand shares, respectively, related to anti-dilutive stock options and restricted stock units.

19. Segment Information

In the first quarter of 2023, and in conjunction with the Company's updated strategic plan, executive leadership realignment and corresponding 2023 divestitures, the Company revised the way it manages the business, evaluates performance and allocates resources, resulting in an updated segment structure comprised of (1) a Medicaid segment, (2) a Medicare segment, (3) a Commercial segment and (4) an Other segment. Prior year information has been adjusted to reflect the change in segment reporting.

The Medicaid, Medicare and Commercial segments represent the government-sponsored or subsidized programs under which the Company offers managed healthcare services. The Other segment includes the Company's pharmacy operations, Envolve Benefit Options' vision and dental services, clinical healthcare, behavioral health, international operations and corporate management company, among others.

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 to evaluate all results of operations. The Company does not report total assets by segment since this is not a metric used to allocate resources or evaluate segment performance.

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

	<u>Medicaid</u>	<u>Medicare</u>	<u>Commercial</u>	<u>Other/Eliminations</u>	<u>Consolidated Total</u>
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	<u>\$ 100,759</u>	<u>\$ 22,261</u>	<u>\$ 24,845</u>	<u>\$ 6,134</u>	<u>\$ 153,999</u>
Medical costs	\$ 78,210	\$ 19,394	\$ 19,816	\$ 1,474	\$ 118,894
Cost of services	\$ 4	\$ —	\$ —	\$ 3,560	\$ 3,564
Gross margin ⁽¹⁾	\$ 8,641	\$ 2,867	\$ 5,029	\$ 1,100	\$ 17,637

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

Segment information for the year ended December 31, 2022, is as follows (\$ in millions):

	Medicaid	Medicare	Commercial	Other/Eliminations	Consolidated Total
Premium	\$ 84,084	\$ 22,484	\$ 17,377	\$ 3,186	\$ 127,131
Service	(1)	—	3	8,346	8,348
Premium and service revenues	84,083	22,484	17,380	11,532	135,479
Premium tax	9,068	—	—	—	9,068
Total external revenues	93,151	22,484	17,380	11,532	144,547
Internal revenues	—	—	—	25,191	25,191
Eliminations	—	—	—	(25,191)	(25,191)
Total revenues	\$ 93,151	\$ 22,484	\$ 17,380	\$ 11,532	\$ 144,547
Medical costs	\$ 75,298	\$ 19,372	\$ 14,092	\$ 2,767	\$ 111,529
Cost of services	\$ —	\$ —	\$ —	\$ 7,032	\$ 7,032
Gross margin ⁽¹⁾	\$ 8,785	\$ 3,112	\$ 3,288	\$ 1,733	\$ 16,918

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

Segment information for the year ended December 31, 2021, is as follows (\$ in millions):

	Medicaid	Medicare	Commercial	Other/Eliminations	Consolidated Total
Premium	\$ 76,127	\$ 17,512	\$ 16,953	\$ 1,727	\$ 112,319
Service	13	—	3	5,648	5,664
Premium and service revenues	76,140	17,512	16,956	7,375	117,983
Premium tax	7,999	—	—	—	7,999
Total external revenues	84,139	17,512	16,956	7,375	125,982
Internal revenues	—	—	—	23,654	23,654
Eliminations	—	—	—	(23,654)	(23,654)
Total revenues	\$ 84,139	\$ 17,512	\$ 16,956	\$ 7,375	\$ 125,982
Medical costs	\$ 67,104	\$ 15,246	\$ 14,689	\$ 1,563	\$ 98,602
Cost of services	\$ —	\$ —	\$ —	\$ 4,894	\$ 4,894
Gross margin ⁽¹⁾	\$ 9,036	\$ 2,266	\$ 2,267	\$ 918	\$ 14,487

⁽¹⁾ 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)

	<u>December 31, 2023</u>	<u>December 31, 2022</u>
ASSETS		
Current assets:		
Cash and cash equivalents	\$ 7	\$ 12
Other current assets	7	6
Total current assets	14	18
Long-term investments	264	66
Investment in subsidiaries	43,853	42,306
Other long-term assets	186	422
Total assets	<u>\$ 44,317</u>	<u>\$ 42,812</u>
LIABILITIES, REDEEMABLE NONCONTROLLING INTERESTS AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Current liabilities	\$ 417	\$ 534
Current portion of long-term debt	110	69
Total current liabilities	527	603
Long-term debt	17,708	17,699
Other long-term liabilities	126	273
Total liabilities	18,361	18,575
Commitments and contingencies		
Redeemable noncontrolling interest	19	56
Stockholders' equity:		
Preferred stock, \$0.001 par value; authorized 10,000 shares; no shares issued or outstanding at December 31, 2023 and December 31, 2022	—	—
Common stock, \$0.001 par value; authorized 800,000 shares; 615,291 issued and 534,484 outstanding at December 31, 2023, and 607,847 issued and 550,754 outstanding at December 31, 2022	1	1
Additional paid-in capital	20,304	20,060
Accumulated other comprehensive (loss)	(652)	(1,132)
Retained earnings	12,043	9,341
Treasury stock, at cost (80,807 and 57,093 shares, respectively)	(5,856)	(4,213)
Total Centene stockholders' equity	25,840	24,057
Nonredeemable noncontrolling interest	97	124
Total stockholders' equity	25,937	24,181
Total liabilities, redeemable noncontrolling interests and stockholders' equity	<u>\$ 44,317</u>	<u>\$ 42,812</u>

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,		
	2023	2022	2021
Expenses:			
Selling, general and administrative expenses	\$ 14	\$ 21	\$ 9
Legal settlement	—	33	1,116
Other income (expense):			
Investment and other income	(47)	55	38
Gain on divestiture	108	13	118
Debt extinguishment	—	14	(125)
Interest expense	(710)	(643)	(641)
(Loss) before income taxes	(663)	(615)	(1,735)
Income tax (benefit)	(118)	(208)	(308)
Net (loss) before equity in subsidiaries	(545)	(407)	(1,427)
Equity in earnings from subsidiaries	3,244	1,609	2,763
Net earnings	2,699	1,202	1,336
Loss attributable to noncontrolling interests	3	—	11
Net earnings attributable to Centene Corporation	\$ 2,702	\$ 1,202	\$ 1,347
Net earnings per common share attributable to Centene Corporation:			
Basic earnings per common share	\$ 4.97	\$ 2.09	\$ 2.31
Diluted earnings per common share	\$ 4.95	\$ 2.07	\$ 2.28

See notes to condensed financial information of registrant.

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

	Year Ended December 31,		
	2023	2022	2021
Cash flows from operating activities:			
Dividends from subsidiaries, return on investment	\$ 2,823	\$ 1,706	\$ 2,194
Payments for legal settlement	(326)	(282)	(298)
Other operating activities, net	(334)	(450)	(582)
Net cash provided by operating activities	<u>2,163</u>	<u>974</u>	<u>1,314</u>
Cash flows from investing activities:			
Capital contributions to subsidiaries	(443)	(880)	(1,217)
Purchases of investments	(202)	(2)	(723)
Sales and maturities of investments	—	—	66
Dividends from subsidiaries, return of investment	85	10	241
Investments in acquisitions	—	(2,431)	(151)
Proceeds from divestitures	325	—	130
Intercompany activities	(357)	5,785	(1,709)
Other investing activities, net	—	3	—
Net cash (used in) provided by investing activities	<u>(592)</u>	<u>2,485</u>	<u>(3,363)</u>
Cash flows from financing activities:			
Proceeds from common stock issuances	44	70	35
Proceeds from long-term debt	2,305	75	9,066
Payments and repurchases of long-term debt	(2,290)	(491)	(7,207)
Common stock repurchases	(1,633)	(3,096)	(297)
Payments for debt extinguishment	—	(14)	(157)
Debt issuance costs	—	—	(72)
Other financing activities, net	(2)	—	22
Net cash (used in) provided by financing activities	<u>(1,576)</u>	<u>(3,456)</u>	<u>1,390</u>
Net increase (decrease) in cash and cash equivalents	<u>(5)</u>	<u>3</u>	<u>(659)</u>
Cash and cash equivalents, beginning of period	12	9	668
Cash and cash equivalents, end of period	<u>\$ 7</u>	<u>\$ 12</u>	<u>\$ 9</u>

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 including, but not limited to, salaries and wages for personnel, rent, utilities, population health management, provider contracting, compliance, member services, claims processing, information technology, cash management, finance and accounting and other services. Beginning in 2023, 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.

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, 2023. 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, 2023, 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, 2023. Our management's assessment of the effectiveness of our internal control over financial reporting as of December 31, 2023, 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, 2023 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, 2023, 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, 2023, 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, 2023 and 2022, 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, 2023, and the related notes (collectively, the consolidated financial statements), and our report dated February 20, 2024 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 20, 2024

Item 9B. Other Information

(a) On February 16, 2024, David P. Thomas, and on February 20, 2024, Christopher A. Koster each entered into the Restrictive Covenant Agreement (the Agreement) pursuant to which they each became eligible for benefits under the Centene Corporation Executive Severance and Change in Control Plan (the Plan), as described below. Our remaining named executive officers have previously executed employment agreements (see Item 15. *Exhibit Index* for additional details).

Centene Corporation Restrictive Covenant Agreement pursuant to the Executive Severance and Change in Control Plan

Under the Agreement, Mr. Koster and Mr. Thomas have each agreed to a non-competition covenant during their respective employment and for 12 months after termination of employment, provided that the termination of employment is not due to a Change in Control Termination (as defined below). Mr. Koster and Mr. Thomas have also agreed to a covenant not to solicit employees or customers during employment and for 12 months after termination of employment for any reason under the Plan. Under the Agreement, Mr. Koster and Mr. Thomas have each waived all rights and benefits pursuant to their prior Executive Severance and Change in Control Agreements, and such agreements were terminated.

Centene Corporation Executive Severance and Change in Control Plan

The purpose of the Plan is to provide benefits to eligible employees of the Company and its United States based subsidiaries, including Mr. Koster and Mr. Thomas, who become unemployed as a result of a Qualifying Termination (as defined below). In order to participate in the Plan, an employee must fulfill certain requirements, including current full-time employment at the level of Senior Vice President or above (or be otherwise designated by the Company as a participant in the Plan) at an entity eligible to participate in the Plan; becoming party to a restrictive covenant agreement (which includes the Agreement described here); not being party to an employment agreement or other agreement with the Company that provides for severance payments (or waiving such rights within 120 days following the effective date of the Plan); and experiencing a Qualifying Termination.

A termination of employment is a "Qualifying Termination" under the Plan only if certain requirements are met, including that the termination occurs as a result of a reduction in force or corporate restructuring, the employee is terminated without cause (other than due to death or disability) or, only at or after a Change in Control, the employee terminates his or her employment for "good reason" as defined in the Plan. The employee must also execute a general release of claims against the Company, among other requirements.

Under the Plan, if Mr. Koster or Mr. Thomas undergoes a Qualifying Termination that is not a Change in Control Termination, he will receive the following payable in a lump sum: (i) one times his 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 performance based restricted stock units vesting based on actual performance and settled at the same time as the other Company officers generally and with any cash long-term incentive plan awards vesting pro rata based on actual performance; and (iv) outplacement assistance for six months following the Qualifying Termination.

If Mr. Koster or Mr. Thomas undergoes a Qualifying Termination within 24 months after a Change in Control (or during the six months prior to a Change in Control, if requested by a third party participating in or causing the Change in Control) (a Change in Control Termination), he will receive the following payable in a lump sum: (i) two times his base salary plus two times his Average Bonus (as defined in the Plan); (ii) the Company portion of COBRA premiums for medical and dental benefits for 18 months; (iii) outstanding equity awards or cash long-term incentive awards will fully vest and become exercisable as of the date of the Change in Control 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 and actual performance prior to the Change in Control; and (iv) outplacement assistance for 6 months following the Qualifying Termination.

This summary is qualified in its entirety by reference to the copy of the Plan attached hereto as Exhibit 10.9 and the Agreement attached hereto as Exhibit 10.31, which are incorporated herein by reference.

(b) During the three months ended December 31, 2023, 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 2024 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 2024 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 and identification of our Audit and Compliance Committee, and our code of ethics will appear in our Proxy Statement for our 2024 annual meeting of stockholders under "Corporate Governance." These portions of our Proxy Statement are incorporated herein by reference.

Item 11. Executive Compensation

Information concerning executive compensation will appear in our Proxy Statement for our 2024 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 2024 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 2024 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 2024 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 2024 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, 2023 and 2022
Consolidated Statements of Operations for the years ended December 31, 2023, 2022 and 2021
Consolidated Statements of Comprehensive Earnings (Loss) for the years ended December 31, 2023, 2022 and 2021
Consolidated Statements of Stockholders' Equity for the years ended December 31, 2023, 2022 and 2021
Consolidated Statements of Cash Flows for the years ended December 31, 2023, 2022 and 2021
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
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	X			
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	* Amended and Restated Non-Employee Directors Deferred Stock Compensation Plan		10-Q	July 28, 2015	10.1
10.5	* Amended and Restated Voluntary Nonqualified Deferred Compensation Plan	X			
10.6	* Centene Corporation 2007 Long-Term Incentive Plan, as Amended		10-K	February 22, 2021	10.6
10.7	* Centene Corporation Short-Term Executive Compensation Plan		10-K	February 22, 2011	10.12

10.8	*	Form of Executive Severance and Change in Control Agreement	10-Q	October 28, 2008	10.3
10.8a	*	Amendment No. 1 of Form of Executive Severance and Change in Control Agreement	10-Q	October 23, 2012	10.3
10.8b	*	Amendment No. 2 of Form of Executive Severance and Change in Control Agreement	10-Q	April 28, 2015	10.1
10.9	*	Executive Severance and Change in Control Plan		X	
10.10	*	Form of Non-statutory Stock Option Agreement (Employees) #1	10-K	February 22, 2021	10.11
10.11	*	Form of Non-statutory Stock Option Agreement (Employees) #2	10-K	February 22, 2022	10.12
10.12	*	Form of Non-statutory Stock Option Agreement (Directors)	10-K	February 21, 2023	10.13
10.13	*	Form of Restricted Stock Agreement (Directors) #1	10-K	February 21, 2023	10.14
10.14	*	Form of Restricted Stock Agreement (Directors) #2	10-Q	July 28, 2023	10.1
10.15	*	Form of Restricted Stock Unit Agreement #1	10-K	February 21, 2017	10.20
10.16	*	Form of Restricted Stock Unit Agreement #2	8-K	December 21, 2020	10.1
10.17	*	Form of Restricted Stock Unit Agreement #3	10-Q	April 25, 2023	10.1
10.18	*	Form of Restricted Stock Unit Agreement #4	10-Q	April 25, 2023	10.2
10.19	*	Form of Performance Based Restricted Stock Unit Agreement #1	10-K	February 21, 2017	10.23
10.20	*	Form of Performance Based Restricted Stock Unit Agreement #2	8-K	December 21, 2020	10.2
10.21	*	Form of Performance Based Restricted Stock Unit Agreement #3	10-Q	April 25, 2023	10.3
10.22	*	Form of Long-Term Incentive Plan Agreement	8-K	December 21, 2020	10.3
10.23		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
10.23a		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
10.24	*	Executive Employment Agreement between Centene Corporation and Sarah M. London, dated April 27, 2022	10-Q	July 26, 2022	10.1
10.24a	*	Amendment of Executive Employment Agreement between Centene Corporation and Sarah M. London, dated February 20, 2023	10-K	February 21, 2023	10.22a
10.25	*	Executive Employment Agreement between Centene Corporation and Andrew Asher, dated April 28, 2022	10-Q	July 26, 2022	10.3
10.25a	*	Amendment of Executive Employment Agreement between Centene Corporation and Andrew Asher, dated February 20, 2023	10-K	February 21, 2023	10.23a
10.26	*	Executive Employment Agreement between Centene Corporation and Kenneth Fasola, dated February 20, 2023	10-K	February 21, 2023	10.24
10.27	*	Executive Employment Agreement between Centene Corporation and James E. Murray, dated February 20, 2023	10-K	February 21, 2023	10.25

10.28	*	Executive Employment Agreement between Centene Corporation and Brent Layton, dated April 27, 2022	10-Q	July 26, 2022	10.2
10.28a	*	Amendment of Executive Employment Agreement between Centene Corporation and Brent Layton dated December 13, 2022	8-K	December 14, 2022	10.1
10.29	*	Transition Services Agreement between Centene Corporation and Kenneth Burdick, dated February 21, 2020	10-K	February 22, 2021	10.25
10.30	*	Executive Officer Cash Severance Policy	10-K	February 21, 2023	10.31
10.31	*	Executive Restricted Covenant Agreement			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, and 333-90976)			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			X
101		The following materials from the Centene Corporation Annual Report on Form 10-K for the fiscal year ended December 31, 2023, 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 20, 2024.

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 20, 2024.

Signature	Title
<u>/s/ Sarah M. London</u> Sarah M. London	Chief Executive Officer (principal executive officer)
<u>/s/ Andrew L. Asher</u> Andrew L. Asher	Executive Vice President, Chief Financial Officer (principal financial officer)
<u>/s/ Katie N. Casso</u> Katie N. Casso	Senior Vice President, Corporate Controller and Chief Accounting Officer (principal accounting officer)
<u>/s/ Jessica L. Blume</u> Jessica L. Blume	Director
<u>/s/ Kenneth A. Burdick</u> Kenneth A. Burdick	Director
<u>/s/ Christopher J. Coughlin</u> Christopher J. Coughlin	Director
<u>/s/ H. James Dallas</u> H. James Dallas	Director
<u>/s/ Wayne S. DeVeydt</u> Wayne S. DeVeydt	Director
<u>/s/ Fred H. Eppinger</u> Fred H. Eppinger	Director
<u>/s/ Monte E. Ford</u> Monte E. Ford	Director
<u>/s/ Lori J. Robinson</u> Lori J. Robinson	Director
<u>/s/ Theodore R. Samuels</u> Theodore R. Samuels	Director

DESCRIPTION OF CENTENE COMMON STOCK

Authorized Capital Stock of Centene

The Centene amended and restated certificate of incorporation provides that the total number of shares of capital stock which may be issued by Centene is 810,000,000, consisting of 800,000,000 shares of common stock, par value \$0.001 per share, and 10,000,000 shares of preferred stock, par value \$0.001 per share.

Voting Rights

The holders of Centene common stock are entitled to one vote on each matter submitted for their vote at any meeting of Centene stockholders for each share of Centene common stock held as of the record date for the meeting, including the election of directors. Holders of Centene common stock do not have cumulative voting rights.

Generally, the affirmative vote of the holders of a majority of the total number of votes cast of Centene capital stock represented at a meeting and entitled to vote on a matter is required in order to approve such matter.

Liquidation Rights

In the event that Centene is liquidated, dissolved or wound up, the holders of Centene common stock will be entitled to share ratably in all assets remaining after the payment of liabilities, subject to any rights of holders of Centene preferred stock prior to distribution.

Dividends

Subject to any preference rights of holders of Centene preferred stock, the holders of Centene common stock are entitled to receive dividends and other distributions in cash, stock or property, if any, declared from time to time by the Centene Board out of legally available funds.

Fully Paid and Non-Assessable

All outstanding shares of Centene common stock are fully paid and non-assessable.

No Preemptive Rights or Conversion Rights

The Centene common stock has no preemptive or conversion rights or other subscription rights.

No Redemption Rights or Sinking Fund

No redemption or sinking fund provisions apply to the Centene common stock.

NYSE Listing

Centene common stock is listed on the NYSE under the symbol "CNC."

Transfer Agent and Registrar

The transfer agent and registrar for the Centene common stock is Broadridge Corporate Issuer Solutions, Inc.

Anti-takeover Provisions

Some of the provisions in the Centene amended and restated certificate of incorporation, the Centene amended and restated by-laws and the General Corporation Law of the State of Delaware ("DGCL") could have the following effects, among others:

- delaying, deferring or preventing a change in control of Centene;
- delaying, deferring or preventing the removal of Centene's existing management or directors;
- deterring potential acquirers from making an offer to the Centene stockholders; and
- limiting the Centene stockholders' opportunity to realize premiums over prevailing market prices of Centene common stock in connection with offers by potential acquirers.

The following is a summary of some of the provisions in the Centene amended and restated certificate of incorporation and the Centene amended and restated by-laws that could have the effects described above. Centene believes that the benefits of increased protection of its potential ability to negotiate with the proponent of an unfriendly or unsolicited proposal to acquire or restructure Centene outweigh the disadvantages of discouraging takeover or acquisition proposals because negotiation of these proposals could result in an improvement of their terms.

Delaware Business Combination Statute

Centene must comply with Section 203 of the DGCL, an anti-takeover law. In general, Section 203 prohibits a publicly held Delaware corporation from engaging in a "business combination" with an "interested stockholder" for a period of three years following the date the person became an interested stockholder, unless the business combination or the transaction in which the person became an interested stockholder is approved in a prescribed manner or certain other exceptions are met. Generally, a "business combination" includes a merger, asset or stock sale, or other transaction resulting in a financial benefit to an interested stockholder. An "interested stockholder" includes a person who, together with affiliates and associates, owns, or did own within three years prior to the determination of interested stockholder status, 15% or more of the corporation's voting stock. The existence of this provision generally will have an anti-takeover effect for transactions not approved in advance by the Centene Board, including discouraging attempts that might result in a premium over the market price for the shares of common stock held by stockholders.

Actions at Meetings of Stockholders; Special Meetings

Centene's amended and restated certificate of incorporation and amended and restated by-laws provide that a special meeting of stockholders may be called at any time by either (i) the Chairman of the Board of Directors, (ii) the Chief Executive Officer, (iii) the Board of Directors or (iv) upon the written request delivered to the secretary of Centene in the manner provided in the by-laws, signed and dated by one or more stockholders of record, or beneficial owners, if any, of Centene who own not less than 10% of the outstanding shares of Centene's common stock. The business transacted at a special meeting shall be limited to (i) the purpose or purposes stated in the notice of the meeting and (ii) any additional matters the Centene Board determines to include in Centene's notice of special meeting.

Action by Written Consent

Centene's amended and restated certificate of incorporation and amended and restated by-laws require that any action required or permitted to be taken by stockholders at an annual or special meeting may be taken by written consent, but only if such action is taken in accordance with the DGCL and Centene's amended and restated certificate of incorporation and amended and restated by-laws. Any stockholder seeking to have the stockholders take an action by written consent must request that a record date be fixed for such purpose by submitting a written notice signed by stockholders holding at least 10% of the voting power of the shares of capital stock entitled to vote on such action.

Board of Directors

Centene's amended and restated certificate of incorporation and amended and restated by-laws provide that the term of office of each person elected as a director, whether to succeed a person whose term of office as a director has expired or to fill any vacancy, will be elected for a term expiring at the next annual meeting of stockholders.

Directors, and Not Stockholders, Fix the Size of the Centene Board

Centene's amended and restated certificate of incorporation and amended and restated by-laws provide that the number of directors will be fixed from time to time exclusively pursuant to a resolution adopted by the Centene Board, but in no event will it consist of less than five nor more than 14 directors.

Board Vacancies to Be Filled by Remaining Directors and Not Stockholders

Under Centene's amended and restated certificate of incorporation and amended and restated by-laws, any vacancy on the Centene Board created by any reason prior to the expiration of the term in which the vacancy occurs will be filled by a majority of the remaining directors, even if less than a quorum. A director elected to fill a vacancy will be elected for the unexpired term of his or her predecessor.

Advance Notice for Stockholder Proposals and Nominations

Centene's amended and restated by-laws contain provisions requiring that advance notice be delivered to Centene of any business to be brought by a stockholder before an annual meeting and providing for procedures to be followed by Centene stockholders in proposing business or nominating persons for election to the Centene Board. Ordinarily, the stockholder must give notice not less than 90 days nor more than 120 days prior to the anniversary date of the immediately preceding annual meeting; provided, however, that in the event that the date of the meeting is not within 30 days before or more than 70 days after such date, notice by the stockholder must be received no earlier than 120 days prior to such meeting and no later than the later of 70 days prior to the meeting or the 10th day following the day on which public disclosure of the date of the annual meeting was first made by Centene. The notice must include information regarding the stockholder making the proposal or director nomination(s), the director nominees (if any) and the proposed business (if any), and other specified matters. The Centene Board may reject any proposals that have not followed these procedures.

Limitation on Liability of Directors; Indemnification

Centene's amended and restated certificate of incorporation provides that no director shall be personally liable to Centene or any of its stockholders for monetary damages for breach of fiduciary duty as a director, except to the extent such exemption from liability or limitation thereof is not permitted under the DGCL as the same exists or may hereafter be amended. If the DGCL is amended hereafter to authorize the further elimination or limitation of the liability of directors, then the liability of directors shall be eliminated or limited to the fullest extent authorized by the DGCL, as so amended. Centene's amended and restated certificate of incorporation further provides that any repeal or modification of this limitation of liability by the Centene stockholders shall not adversely affect any right or protection of a director of Centene existing at the time of such repeal or modification with respect to acts or omissions occurring prior to such repeal or modification.

Centene's amended and restated certificate of incorporation requires that Centene indemnify its directors and officers to the fullest extent authorized or permitted by law, as now or hereafter in effect, and that such right to indemnification shall continue as to a person who has ceased to be a director or officer and shall inure to the benefit of his or her heirs, executors and personal and legal representatives. Except for proceedings to enforce rights to indemnification, however, Centene shall not be obligated to indemnify in connection with a proceeding (or part thereof) if such director, officer or successor in interest initiated such proceeding (or part thereof) unless such proceeding was authorized or consented to by the Centene Board. The right to indemnification includes the right to be paid the expenses incurred in defending or otherwise participating in any proceeding in advance of its final disposition. Any repeal or modification by the stockholders of indemnification or advancement rights shall not adversely affect any rights to indemnification and to the advancement of expenses of a director or officer of Centene existing at the time of such repeal or modification with respect to any acts or omissions occurring prior to such repeal or modification.

The Centene Board may in its discretion provide rights to indemnification and to the advancement of expenses to employees and agents of Centene similar to those described above.

The inclusion of these provisions in the Centene amended and restated certificate of incorporation and amended and restated by-laws may have the effect of reducing the likelihood of derivative litigation against Centene's directors and may discourage or deter Centene or its stockholders from bringing a lawsuit against Centene's directors for breach of their duty of care, even though such an action, if successful, might otherwise have benefited Centene and its stockholders.

General Provisions Related to Centene Preferred Stock

The following is a description of general terms and provisions of the Centene preferred stock. All of the terms of the Centene preferred stock are, or will be contained in Centene's amended and restated certificate of incorporation, or in one or more certificates of designation relating to each series of the preferred stock.

The Centene Board is authorized, without further stockholder approval but subject to applicable rules of the NYSE and any limitations prescribed by law, to issue up to ten million shares of preferred stock from time to time. The Centene Board has the discretion to provide for the issuance of all or any shares of preferred stock in one or more classes or series, and to fix for each such class or series such voting powers, full or limited, or no voting powers, and such designations, preferences and relative, participating, optional or other special rights and such qualifications, limitations or restrictions thereof, as shall be stated and expressed in the resolution or resolutions adopted by the board of directors providing for the issuance of such class or series, including, without limitation, the authority to provide that any such class or series may be:

- subject to redemption at such time or times and at such price or prices;
- entitled to receive dividends (which may be cumulative or non-cumulative) at such rates, on such conditions, and at such times, and payable in preference to, or in such relation to, the dividends payable on any other class or classes or any other series;
- entitled to such rights upon the dissolution of Centene or upon any distribution of Centene's assets; or
- convertible into, or exchangeable for, shares of any other class or classes of stock or of any other series of the same or any other class or classes of stock of Centene at such price or prices or at such rates of exchange and with such adjustments as the board may determine.

The purpose of authorizing the Centene Board to issue preferred stock and determine its rights and preferences is to eliminate delays associated with a stockholder vote on specific issuances. The issuance of preferred stock may provide desirable flexibility in connection with possible acquisitions and other corporate purposes, but could have the effect of making it more difficult for a third party to acquire, or could discourage a third party from acquiring, a majority of Centene's outstanding voting stock.

Certain Effects of Authorized but Unissued Stock

Centene may issue additional shares of common stock or preferred stock without stockholder approval, subject to applicable rules of the NYSE and Delaware law, for a variety of corporate purposes, including future public or private offerings to raise additional capital, corporate acquisitions, and employee benefit plans and equity grants. The existence of unissued and unreserved common and preferred stock may enable Centene to issue shares to persons who are friendly to current management, which could discourage an attempt to obtain control of Centene by means of a proxy contest, tender offer, merger or otherwise. Centene will not solicit approval of its stockholders for issuance of common and preferred stock unless the Centene Board believes that approval is advisable or is required by applicable rules of the NYSE or Delaware law.

**Seventh Amendment and Restatement of the
Centene Corporation Voluntary
Nonqualified Deferred Compensation Plan**

**ARTICLE I
PURPOSE AND EFFECTIVE DATE**

The purpose of the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan ("Plan") is to aid Centene Corporation and its subsidiaries in retaining and attracting executive employees by providing them with tax deferred savings opportunities. The Plan is unfunded and provides a select group of management and highly compensated employees within the meaning of Sections 201(2), 301(a)(3) and 401(a)(1) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), of Centene Corporation with the opportunity to elect to defer receipt of specified portions of compensation, and to have these deferred amounts treated as if invested in specified hypothetical investment benchmarks. The Plan is intended to conform to the requirements of Code Section 409A. A Participant's Deferral Account that was earned and vested prior to January 1, 2005, plus subsequent earnings thereon, shall not be subject to the terms of this Plan but shall be subject to the terms of the prior plan dated June 1, 2002. The Plan has been amended and restated on six previous occasions. This Seventh Amendment and Restatement of the Plan shall be effective December 7, 2023 (the "Effective Date").

**ARTICLE II
DEFINITIONS**

For the purposes of this Plan, the following words and phrases shall have the meanings indicated, unless the context clearly indicates otherwise:

Section 2.01

Administrative Committee. "Administrative Committee" or "Committee" means the Company's Head of Total Rewards or other individual(s) to whom the Compensation Committee has delegated the authority to take action under the Plan; provided that, in the case of any individual who is an "officer" within the meaning of Rule 16a-1(f) under the Exchange Act, to the extent necessary to satisfy applicable law or New York Stock Exchange Listing Standards, "Committee" shall mean the Compensation Committee.

Section 2.02

Base Salary. "Base Salary" means the base rate of cash compensation paid by the Company to or for the benefit of a Participant for services rendered or labor performed while a Participant is employed by the Company, including base pay a Participant could have received in cash in lieu of (A) deferrals pursuant to Section 4.02 and (B) contributions made on their behalf to any qualified plan maintained by the Company or to any cafeteria plan under Code Section 125 maintained by the Company.

Section 2.03

Base Salary Deferral. "Base Salary Deferral" means the amount of a Participant's Base Salary which the Participant elects to have withheld on a pre-tax basis from their Base Salary and credited to their Deferral Account pursuant to Section 4.02.

Section 2.04

Beneficiary. "Beneficiary" means the person, persons or entity designated by the Participant to receive any benefits payable under the Plan pursuant to Article VIII.

Section 2.05

Board. "Board" means the Board of Directors of Centene Corporation.

Section 2.06

Annual Bonus Compensation. "Annual Bonus Compensation" or "Bonus Compensation" means the Participant's compensation under the Company bonus plan that is eligible for payment once per year, based on funding approval by the Board, and is determined by established metrics.

Section 2.07

Annual Bonus Deferral. "Annual Bonus Deferral" means the amount of a Participant's Annual Bonus Compensation which the Participant elects to have withheld on a pre-tax basis from their Annual Bonus Compensation and credited to their Deferral Account pursuant to Section 4.02.

Section 2.08

Cash Long-Term Incentive Plan Deferral. "Cash Long-Term Incentive Plan Deferral" means the amount of a Participant's Cash LTIP Compensation which the Participant elects to have withheld on a pre-tax basis from their Cash LTIP Compensation and credited to their Deferral Account pursuant to Section 4.02.

Section 2.09

Cash LTIP Compensation. "Cash LTIP Compensation" means the Participant's compensation under the Cash Long-Term Incentive Plan that is eligible for payment at the end of the relevant performance period, and is determined by established metrics.

Section 2.10

Change in Control. For purposes of this Plan, a "Change in Control" shall be deemed to have occurred if any of the events set forth in any one of the following clauses shall occur: (A) any Person (as defined in section 3(a)(9) of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), and as such term is modified in sections 13(d) and 14(d) of the Exchange Act), is or becomes the "beneficial owner" (as defined in Rule 13d-3 under the Exchange Act), directly or indirectly, of securities of Centene Corporation representing forty percent (40%) or more of the combined voting power of Centene Corporation's then outstanding securities; (B) individuals who, as of the Effective Date, constitute the Board (the "Incumbent Board"), cease for any reason to constitute a majority thereof (provided, however, that an individual becoming a Board member subsequent to the Effective Date whose election, or nomination for election by the stockholders of Centene Corporation, was approved by at least a majority of the directors then comprising the Incumbent Board shall be included within the definition of Incumbent Board, but excluding, for this purpose, any such individual whose initial assumption of office occurs as a result of either an actual election contest (or such terms used in Rule 14a-11 of Regulation 14A promulgated under the Exchange Act) or other actual or threatened solicitation of proxies or consents by or on behalf of a person other than the Board); or (C) the stockholders of Centene Corporation consummate a merger or consolidation of Centene Corporation with any other corporation, other than a merger or consolidation which would result in the voting securities of Centene Corporation outstanding immediately prior thereto continuing to represent (either by remaining outstanding or by being converted into voting securities of the surviving entity) at least fifty percent (50%) of the combined voting power of the voting securities of Centene Corporation or such surviving entity outstanding immediately after such merger or consolidation. In order to qualify as Change in Control, the event or events must also qualify as a change in ownership or effective control of the Company or in the ownership of a substantial portion of the assets of Centene Corporation within the meaning of Code Section 409A.

Section 2.11

Code. "Code" shall mean the Internal Revenue Code of 1986, as amended. References to any provision of the Code or regulation (including a proposed regulation) thereunder shall include any successor provisions or regulations.

Section 2.12

Company. "Company" means Centene Corporation, its successors, any subsidiary or affiliated organizations authorized by the Board or the Compensation Committee to participate in the Plan and any organization into which or with which Centene Corporation may merge or consolidate or to which all or substantially all of its assets may be transferred.

Section 2.13

Compensation Committee. "Compensation Committee" means the Compensation and Talent Committee of the Board or any successor thereto.

Section 2.14

Deferral Account. "Deferral Account" means the account maintained by the Administrative Committee for each Participant pursuant to Article VI.

Section 2.15

Deferral Election. "Deferral Election" means an election by a Participant to defer Eligible Compensation.

Section 2.16

Deferral Period. "Deferral Period" means the period after which payment of the Deferred Amount is to be made or begin to be made.

Section 2.17

Deferred Amount. "Deferred Amount" means the amount of Eligible Compensation for the Plan Year or performance period to which the Participation Agreement relates that is to be deferred under the Plan.

Section 2.18

Designee. "Designee" shall mean the Company's Head of Total Rewards or other individuals to whom the Committee has delegated the authority to take action under the Plan. Wherever Committee is referenced in the Plan, it shall be deemed to also refer to Designee; provided that, in the case of any individual who is an "officer" within the meaning of Rule 16a-1(f) under the Exchange Act, to the extent necessary to satisfy applicable law or New York Stock Exchange Listing Standards, "Designee" shall mean the Compensation Committee.

Section 2.19

Disability. "Disability" shall mean the disability of the Participant as defined in Code Section 409A(a)(2)(C) of the Code.

Section 2.20

Election Period. "Election Period" means the period established by the Committee with respect to each Plan Year or performance period during which Deferral Elections for such Plan Year or performance period must be made in accordance with the requirements of Code Section 409A, as follows:

- (a) General Rule. Except as provided in (b) and (c) below, the Election Period shall end no later than the last day of the Plan Year immediately preceding the first Plan Year in which any services relating to the Eligible Compensation are performed.
- (b) Performance-Based Compensation. If any Performance-Based Compensation constitutes "performance-based compensation" within the meaning of Reg. 1.409A-1(e), then the Election Period for such amounts shall end no later than six months before the end of the Plan Year during which such Performance-Based Compensation is earned (and in no event later than the date on which any portion of such Performance-Based Compensation becomes readily ascertainable).
- (c) Newly Eligible Participant. The Election Period for an individual who is newly eligible to be a Participant shall end no later than thirty (30) days after the individual first becomes eligible to participate in the Plan and shall apply only with respect to compensation earned after the date of the Deferral Election.

Section 2.21

Eligible Compensation. "Eligible Compensation" means any Base Salary, Annual Bonus Compensation, Incentive Compensation, and/or Cash LTIP Compensation otherwise payable with respect to a Plan Year or performance period.

Section 2.22

"Eligible Employee" means an employee of the Company who is selected by the Committee to participate in the Plan. Participation in the Plan is limited to a select group of the Company's key management or highly compensated employees.

Section 2.23

ERISA. "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

Section 2.24

Form of Payment. "Form of Payment" means payment in one lump sum or in substantially equal annual installments of two (2) to fifteen (15) years. If the Form of Payment is substantially equal annual installments, each installment shall constitute a separate payment for purposes of Code Section 409A.

Section 2.25

Hardship Withdrawal. "Hardship Withdrawal" means the early payment of all or part of the balance in a Deferral Account(s) in the event of an Unforeseeable Emergency, as defined in Code Section 409A(a)(2)(B)(ii), pursuant to Section 7.08.

Section 2.26

Hypothetical Investment Benchmark. "Hypothetical Investment Benchmark" shall mean the phantom investment benchmarks which are used to measure the return credited to a Participant's Deferral Account.

Section 2.27

Incentive Compensation. "Incentive Compensation" means the amount awarded to a Participant for a Plan Year under any incentive plan maintained by the Company, such as commission or other sales-based compensation plans, as approved in the sole discretion of the Committee.

Section 2.28

Matching Contribution. "Matching Contribution" means the amount of any matching contribution that the Company will make to a Participant's Deferral Account.

Section 2.29

Outside Date. "Outside Date" means the later of (i) the last day of the calendar year in which a Deferred Amount is scheduled to be paid and (ii) the 15th day of the third calendar month following the date that the Deferred Amount is scheduled to be paid, in each case, as determined in accordance with Reg. 1-409A-3(d).

Section 2.30

Participant. "Participant" means any individual who is an Eligible Employee and who makes a Deferral Election by submitting a Participation Agreement as provided in Article IV.

Section 2.31

Participation Agreement. "Participation Agreement" means an agreement submitted by a Participant in accordance with Article IV.

Section 2.32

Performance-Based Compensation. "Performance-Based Compensation" means any Annual Bonus Compensation, Cash LTIP Compensation or Incentive Compensation.

Section 2.33

Plan Year. "Plan Year" means a twelve-month period beginning January 1 and ending the following December 31.

Section 2.34

Qualified Retirement. For Participants hired on or after January 1, 2019, "Qualified Retirement" means retirement of a Participant from the Company after attaining age 55 with at least ten (10) years of service. For Participants hired prior to January 1, 2019, "Qualified Retirement" is defined as the attainment of age 65 or age 55 with at least five (5) years of service. Years of service will be calculated in accordance with the method adopted by the Company.

Section 2.35

Qualified Retiree. "Qualified Retiree" means a Participant who has experienced a Qualified Retirement.

Section 2.36

Separation from Service. "Separation from Service" means a termination of employment or service due to death, disability or otherwise when the Company reasonably anticipates that no further services will be performed after a certain date or that the level of bona fide services the Participant would perform after such date (whether as an employee or as an independent contractor) would permanently decrease to 20 percent or less of the average rate of services performed over the immediately preceding 36-month period (or the full period of services to the Company if the Participant has been providing services for less than 36 months) prior to such reduction. If a Participant ceases or reduces services under a bona fide leave of absence, a Separation from Service occurs after the close of the six (6)-month anniversary of such leave, provided however that the Separation from Service shall be delayed to the extent that the Participant has a statutory or contractual right to reemployment. Determination of whether a Separation from Service occurs shall be made in a manner that is consistent with Reg. 1.409A-1(h).

Section 2.37

Signing Bonus. "Signing Bonus" means the bonus offered to selected Participants in connection with an acquisition of another entity by the Company. The decision whether a Signing Bonus shall be eligible for deferral pursuant to the terms of this Plan shall be made in the sole discretion of the Committee prior to the Signing Bonus being presented in an offer letter or employment agreement with the Participant.

Section 2.38

Specified Employee. "Specified Employee" means a "specified employee" within the meaning of Code Section 409A(a)(2)(B) and Reg. 1.409A-1(i).

Section 2.39

Unforeseeable Emergency. "Unforeseeable Emergency" means severe financial hardship to the Participant resulting from a sudden and unexpected illness or accident of the Participant or a dependent of the Participant, loss of the Participant's property due to casualty, or other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the Participant. Determination of whether an Unforeseeable Emergency occurs shall be made by the Committee in a manner that is consistent with Reg. 1.409A-3(i)(3).

Section 2.40

Valuation Date. "Valuation Date" means the last day of the calendar month or such other date as the Committee in its sole discretion may determine.

ARTICLE III ADMINISTRATION

Section 3.01

Administrative Committee Duties. The Committee shall be responsible for the administration of this Plan and shall have all powers necessary to administer this Plan, including discretionary authority to determine eligibility for participation in the Plan and to decide claims under the terms of this Plan, except to the extent that any such powers are vested in any other person administering this Plan by the Committee pursuant to this Section 3.01. The Committee may from time to time establish rules for the administration of this Plan, and it shall have the exclusive right to interpret this Plan and to decide any matters arising in connection with the administration and operation of this Plan. All rules, interpretations and decisions of the Committee shall be conclusive and binding on the Company, Participants and Beneficiaries.

The Committee may delegate responsibility for performing certain administrative functions under this Plan to certain employees of the Company or outside third parties. The Committee shall be responsible for determining issues related to eligibility, Hypothetical Investment Benchmarks, distribution of Deferred Amounts, determination of account balances, crediting of hypothetical earnings and debiting of hypothetical losses and of distributions, in-service withdrawals, Deferral Elections and any other duties concerning the day-to-day operation of this Plan. The Committee may designate one of its members as a Chairperson and may retain and supervise outside providers, third party administrators, record keepers and professionals (including in-house professionals) to perform any or all of the duties delegated to it hereunder.

Neither the Committee nor a member of the Board shall be liable for any act or action hereunder, whether of omission or commission, by any other member or employee or by any agent to whom duties in connection with the administration of this Plan have been delegated or for anything done or omitted to be done in connection with this Plan. The Committee shall keep records of all of their respective proceedings and the Committee shall keep records of all payments made to Participants or Beneficiaries and payments made for expenses or otherwise.

The Company shall, to the fullest extent permitted by law, indemnify each Board member, officer or employee of the Company (including the heirs, executors, administrators and other personal representatives of such person) and each member of the Committee against expenses (including attorneys' fees), judgments, fines, amounts paid in settlement, actually and reasonably incurred by such person in connection with any threatened, pending or actual suit, action or proceeding (whether civil, criminal, administrative or investigative in nature or otherwise) in which such person may be involved by reason of the fact that he or she is or was serving this Plan in any capacity at the request of the Company or the Committee.

Any expense incurred by the Company or the Committee relative to the administration of this Plan shall be paid by the Company.

Section 3.02

Claim Procedure. If a Participant or Beneficiary makes a written request alleging a right to receive payments under this Plan or alleging a right to receive an adjustment in benefits being paid under this Plan, such actions shall be treated as a claim for benefits. All claims for benefits under this Plan shall be sent to the Committee. If the Committee determines that any individual who has claimed a right to receive benefits, or different benefits, under this Plan is not entitled to receive all or any part of the benefits claimed, the Committee shall inform the claimant in writing of such determination and the reasons therefore in terms calculated to be understood by the claimant. The notice shall be sent within 90 days of the claim unless the Committee determines that additional time, not exceeding 90 days, is needed and so notifies the Participant. The notice shall make specific reference to the pertinent Plan provisions on which the denial is based, and shall describe any additional material or information that is necessary. Such notice shall, in addition, inform the claimant of the procedure that the claimant should follow to take advantage of the review procedures set forth below in the event the claimant desires to contest the denial of the claim. The claimant may within 90 days thereafter submit in writing to the Committee a notice that the claimant contests the denial of their claim and desires a further review by the Committee. The Committee shall within 60 days thereafter review the claim and authorize the claimant to review pertinent documents and submit issues and comments relating to the claim to the Committee. The Committee will render a final decision on behalf of the Company with specific reasons therefor in writing and will transmit it to the claimant within 60 days of the written request for review, unless the Chairperson of the Committee determines that additional time, not exceeding 60 days, is needed, and so notifies the Participant. If the Committee fails to respond to a claim submitted in accordance with the foregoing within 60 days or any such extended period, the Company shall be deemed to have denied the claim.

ARTICLE IV PARTICIPATION

Section 4.01

Participation. Participation in the Plan shall be limited to executives who (i) meet such eligibility criteria as the Committee shall establish from time to time, and (ii) elect to participate in this Plan by submitting a Participation Agreement via the third party administrator's website during the defined Open Enrollment period. A Participation Agreement must be submitted prior to the end of the applicable Election Period and, except as otherwise determined by the Committee in accordance with Code Section 409A, the Deferral Election thereunder shall be irrevocable on the last day of the Election Period. Any Eligible Employee may participate in the Plan commencing as of the first day of the pay period commencing on or following the effective date of such Eligible Employee's participation in the Plan occurring on or after the date on which he or she becomes an Eligible Employee.

Section 4.02

Contents of Participation Agreement. Subject to Article VII, each Participation Agreement shall set forth: (i) the Deferred Amount, expressed as a percentage of the Base Salary, Annual Bonus Compensation or Cash LTIP Compensation for such Plan Year or performance period; provided, that the minimum Deferred Amount for any Plan Year or performance period shall not be less than one percent (1%) of such Base Salary, Annual Bonus Compensation or Cash LTIP Compensation for such Plan Year or performance period and the maximum Deferred Amount shall not exceed eighty percent (80%) thereof; (ii) the Deferral Period, which shall be the earlier of (A) a number of full years, not less than three, and (B) the period ending upon the Separation from Service of the Participant, and (iii) the Form of Payment, which may be a lump sum or in substantially equal annual installments of two (2) to fifteen (15) years (except as otherwise set forth in Section 7.04).

Section 4.03

Modification or Revocation of Election by Participant. Except in the event of a Hardship Withdrawal in accordance with Section 7.08, a Participant may not change the Deferred Amount following expiration of the relevant Election Period.

The Deferral Period may be extended pursuant to Section 7.11 of this Plan.

Section 4.04

Deferral of Signing Bonuses. Notwithstanding any provision to the contrary, the deferral of a Signing Bonus offered to selected Participants in connection with an acquisition shall be governed exclusively by this Section 4.04. The decision whether to offer the deferral opportunity with respect to all or any portion of a Signing Bonus shall be made in the sole discretion of the Committee. In the event the Committee decides to offer such deferral option to a Participant, the election to defer shall be included in the offer letter or employment agreement presented to such Participant. In the event a deferral option is offered with respect to a Signing Bonus, any such deferrals shall not be eligible for Matching Contributions described in Section 7.02.

**ARTICLE V
DEFERRED COMPENSATION**

Section 5.01

Elective Deferred Compensation. The Deferred Amount of a Participant with respect to each Plan Year of participation in the Plan shall be credited by the Committee, or designee, to the Participant's Deferral Account as and when such Deferred Amount would otherwise have been paid to the Participant. To the extent that the Company is required to withhold any taxes or other amounts from the Deferred Amount pursuant to any state, Federal or local law, such amounts shall be taken out of other compensation eligible to be paid to the Participant that is not deferred under this Plan. However, if the Participant elects to defer a large percentage of Eligible Compensation and the election does not allow enough remaining compensation for required withholdings or deductions, the withholdings and deductions will be subtracted from the Eligible Compensation that is not subject to the Deferral Election first, followed by a reduction of the Deferred Amount in accordance with Section 7.10.

Section 5.02

Vesting of Deferral Account. Except as provided in Section 7.03, a Participant shall be 100% vested in their Deferral Account at all times.

**ARTICLE VI
MAINTENANCE AND INVESTMENT OF ACCOUNTS**

Section 6.01

Maintenance of Accounts. Separate Deferral Accounts shall be maintained for each Participant. More than one Deferral Account may be maintained for a Participant as necessary to reflect (a) various Hypothetical Investment Benchmarks and/or (b) separate Participation Agreements specifying different Deferral Periods and/or Forms of Payment. A Participant's Deferral Account(s) shall be utilized solely as a device for the measurement and determination of the amounts to be paid to the Participant pursuant to this Plan, and shall not constitute or be treated as a trust fund of any kind. The Committee, or Designee, shall determine the balance of each Deferral Account, as of each Valuation Date immediately following the date that a payment is due from such Deferral Account.

Section 6.02

Hypothetical Investment Benchmarks. Each Participant shall be entitled to direct the manner in which their Deferral Accounts will be deemed to be invested, selecting among the Hypothetical Investment Benchmarks specified in Appendix A hereto, as amended by the Committee from time to time, and in accordance with such rules, regulations and procedures as the Committee may establish from time to time. Notwithstanding anything to the contrary herein, earnings and losses based on a Participant's investment elections shall begin to accrue as of the date such Participant's Deferral Amounts are credited to their Deferral Accounts.

Section 6.03

Statement of Accounts. Participants will have the ability to access account information via a web site provided by the designated third party administrator. Participants may also receive an account statement upon a written request to the Committee.

**ARTICLE VII
BENEFITS**

Section 7.01

Time and Form of Payment. At the end of the Deferral Period for each Deferral Account, the Company shall pay to the Participant the balance of such Deferral Account at the time or times elected by the Participant in the applicable Participation Agreement; provided that if the Participant has elected to receive payments from a Deferral Account in a lump sum, the Company shall pay the balance in such Deferral Account (determined as of the Valuation Date immediately following the end of the Deferral Period) in a lump sum in cash on or as soon as practicable following the end of the Deferral Period and not later than the applicable Outside Date. If the Participant has elected to receive payments from a Deferral Account in installments, the Company shall make annual cash only payments from such Deferral Account, each of which shall consist of an amount equal to (i) the balance of such Deferral Account as of the Valuation Date immediately following the date that a payment is due from such Deferral Account times (ii) a fraction, the numerator of which is one and the denominator of which is the number of remaining installments (including the installment being paid). The first such installment shall be paid on or as soon as practicable following the end of the Deferral Period and not later than the applicable Outside Date and each subsequent installment shall be paid on or as soon as practicable following the anniversary of such first payment but no later than the applicable Outside Date. Each such installment shall be deemed to be made on a pro rata basis from each of the different deemed investments of the Deferral Account (if there is more than one such deemed investment).

Section 7.02

Matching Contribution. Each Participant who elects to make deferrals of Eligible Compensation to the Plan will be eligible to receive a Matching Contribution equal to fifty percent (50%) of the first six percent (6%) of the Participant's Eligible Compensation being deferred to the Plan for such Plan Year (excluding deferrals to the Plan from the Participant's Cash Long-Term Incentive Plan and stock based compensation), reduced by any matching contributions made by the Company to the Centene Management Corporation Retirement Plan ("401(k) Plan") for such Plan Year. When due, Matching Contributions shall be credited to a Participant's account in conjunction with the Company's regular payroll schedule.

Section 7.03

Matching Contribution Vesting. Participants will vest in Matching Contributions as set forth under the 401(k) plan. The vesting schedule is:

Less than 1 year	0%
1 year	10%
2 years	30%
3 years	60%
4 years	80%
5 years	100%

Section 7.04

Separation from Service and Qualified Retirement. Subject to Section 7.01 and Section 7.07 hereof, if a Participant has elected to have the balance of his or her Deferral Account distributed upon Qualified Retirement or other Separation from Service, the account balance of the Participant (determined as of the Valuation Date immediately following the date that a payment is due from such Deferral Account) shall be distributed following the Qualified Retirement or other Separation from Service in installments or a lump sum in accordance with Section 7.01 of the Plan and as elected in the applicable Participation Agreement.

For these purposes, a Participant who elects to have his or her Deferral Account distributed upon Qualified Retirement may choose between a lump sum or annual installments which do not exceed fifteen (15) years. Participants who terminate employment and who experience a Separation from Service but do not satisfy the Qualified Retirement definition shall make a one-time election at the time of the Participant's first Deferral Election under this Plan of a lump sum or annual installments not to exceed five (5) years.

Deferral Elections applicable to Annual Bonus Compensation and/or Cash LTIP Compensation earned in the Plan Year, but paid following the end of the Plan Year, will be honored for Participants who had a Qualified Retirement or a Separation from Service during the Plan Year. In addition, a Participant who experiences a Qualified Retirement or Separation from Service will be allowed to defer Annual Bonus Compensation and/or Cash LTIP Compensation payments that are earned during service with the Company but which are paid after such Qualified Retirement or Separation from Service.

However, if a Participant who experiences a Qualified Retirement or Separation from Service has received a full distribution and has a zero-account balance at the time of the Annual Bonus Compensation or Cash LTIP Compensation payment, no deferral will be taken from such Annual Bonus Compensation or Cash LTIP Compensation payment.

Section 7.05

In-Service Distributions. Subject to Section 7.01 hereof, if a Participant has elected to defer Eligible Compensation under the Plan for a stated number of years, the account balance of the Participant (determined as of the Valuation Date immediately following the date that a payment is due from the Participant's Deferral Account) shall be distributed in installments or a lump sum in accordance with the Plan and as elected in the Participation Agreement.

Section 7.06

Death or Disability. Notwithstanding the provisions of Section 7.04 and Section 7.05 hereof and any Participation Agreement, if a Participant dies or experiences a Disability prior to Qualified Retirement or other Separation from Service and prior to receiving full payment of his or her Deferral Account(s), the Company shall pay the remaining balance (determined as of the Valuation Date immediately following such death or determination of Disability) to the Participant or the Participant's Beneficiary or Beneficiaries (as the case may be) in a lump sum in cash only (notwithstanding Section 7.01 hereof) on or as soon as practicable following the occurrence of such event and not later than the applicable Outside Date. Subject to Section 6.02 hereof, the amount distributable under the preceding sentence of this Section 7.06 shall be based on the Participant's investment selections.

Section 7.07

Delay for Specified Employees. Notwithstanding this Article VII, if a Deferral Period ceases upon Separation from Service (other than for death or Disability), payments to a Participant who is a Specified Employee shall not be made until the close of the six (6)-month anniversary of such Separation from Service (determined as of the Valuation Date immediately following such six (6)-month anniversary). If during such six (6)-month delay a Participant dies, payments shall be made pursuant to Section 7.06.

Section 7.08

Hardship Withdrawals. Notwithstanding the provisions of Section 7.01 and any Participation Agreement, a Participant shall be entitled to early payment of all or part of the balance in their Deferral Account(s) in the event of an Unforeseeable Emergency, in accordance with this Section 7.08 and Reg. 1.409A-3(i)(3)(ii). A distribution pursuant to this Section 7.08 may only be made to the extent reasonably needed to satisfy the Unforeseeable Emergency need (which may include taxes or penalties reasonably anticipated to result from the distribution), and may not be made if such need is or may be relieved (i) through reimbursement or compensation by insurance or otherwise, (ii) by liquidation of the Participant's assets to the extent such liquidation would not itself cause severe financial hardship, or (iii) by cessation of participation in the Plan. An application for an early payment under this Section 7.08 shall be made to the Committee in such form and in accordance with such procedures as the Committee shall determine from time to time. The determination of whether and in what amount and form a distribution will be permitted pursuant to this Section 7.08 shall be made solely by the Committee pursuant to Reg. 1.409A-3(i)(3)(iii).

Section 7.09

Change in Control Election. In the event of a Separation from Service within two years following a Change in Control (a "Change in Control Termination"), the participant's account balance will be paid out as specified in their Change in Control election, if any. This is a separate election from the Form of Payment election and this election applies to all Plan Years. The Participant can elect to have the same distribution schedule as previously elected, a lump sum payment or installments over two (2) to fifteen (15) years. The first such installment shall be paid on or as soon as practicable after the Separation from Service and not later than the applicable Outside Date and each subsequent installment shall be paid on or as soon as practicable following the anniversary of such first payment but no later than the applicable Outside Date. If there is no Change in Control election at the time a Change in Control occurs, the Participant's previous elections will be the default and will be followed.

Section 7.10

Withholding of Taxes. Notwithstanding any other provision of this Plan, the Company shall withhold from payments made hereunder any amounts required to be so withheld by any applicable law or regulation.

Section 7.11

Changes in Payment Elections. A Participant may modify the time or the form of payment elections made on his or her Participation Agreement in respect of an in-service distribution or payment upon Qualified Retirement, death or Disability (but not Separation from Service under circumstances other than Qualified Retirement) under the following circumstances pursuant to Reg. 1-409A-2(b)(1): (i) any such election to modify may not take effect until at least twelve (12) months following the date of such election; (ii) in the case of an election related to a payment not described in Section 7.06 (Death or Disability) or Section 7.08 (Hardship Withdrawals), the election must result in payment being made no earlier than five (5) years following the date upon which the payment would otherwise would have been made; and (iii) if the election is related to payment at a specified time or pursuant to a fixed schedule, the Participant must make the election not less than twelve (12) months prior to the date the payment is scheduled to be made. If the participant experiences a Separation from Service before the required 12-month period elapses, the modification of the time or the form of payment elections will be disregarded.

ARTICLE VIII BENEFICIARY DESIGNATION

Section 8.01

Beneficiary Designation. Each Participant shall have the right, at any time, to designate any person, persons or entity as their Beneficiary or Beneficiaries. A Beneficiary designation shall be made, and may be amended, by the Participant by accessing the web site of the third party administrator and making such changes.

Section 8.02

No Beneficiary Designation. If a Participant fails to designate a Beneficiary as provided above, or if all designated Beneficiaries predecease the Participant, then the Participant's Beneficiary shall be deemed to be the Participant's estate.

ARTICLE IX AMENDMENT AND TERMINATION OF PLAN

Section 9.01

Amendment. The Board or the Committee may at any time amend this Plan in whole or in part, provided, however, that, except as required to comply with applicable law (including Code Section 409A) no amendment shall be effective to decrease the balance in any Deferral Account as accrued at the time of such amendment, nor shall any amendment otherwise have a retroactive effect. Interpretation of the Plan by the Board or the Committee shall be made in a manner that is consistent with the intent that the Plan conform to the requirements of Code Section 409A.

Section 9.02

Company's Right to Terminate. The Board or the Committee may at any time terminate the Plan with respect to future Participation Agreements. The Board or the Committee may also terminate the Plan in its entirety at any time for any reason, including without limitation if, in its judgment, the continuance of the Plan, the tax, accounting, or other effects thereof, or potential payments thereunder would not be in the best interests of the Company, and upon any such termination, the Company shall immediately pay to each Participant in a lump sum the accrued balance in their Deferral Account (determined as of the most recent Valuation Date preceding the termination date). Such termination, however, shall be made in a manner that conforms to the requirements of Code Section 409A.

ARTICLE X MISCELLANEOUS

Section 10.01

Unfunded Plan. This Plan is intended to be an unfunded plan maintained primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees, within the meaning of Sections 201, 301 and 401 of ERISA. All payments pursuant to the Plan shall be made from the general funds of the Company and no special or separate fund shall be established or other segregation of assets made to assure payment. No Participant or other person shall have under any circumstances any interest in any particular property or assets of the Company as a result of participating in the Plan. Notwithstanding the foregoing, the Company may (but shall not be obligated to) create one or more grantor trusts, the assets of which are subject to the claims of the Company's creditors, to assist it in accumulating funds to pay its obligations under the Plan.

Section 10.02

No Assignability. Except as specifically set forth in the Plan with respect to the designation of Beneficiaries, neither a Participant nor any other person shall have any right to commute, sell, assign, transfer, pledge, anticipate, mortgage or otherwise encumber, transfer, hypothecate or convey in advance of actual receipt the amounts, if any, payable hereunder, or any part thereof, which are, and all rights to which are, expressly declared to be unassignable and non-transferable. No part of the amounts payable shall, prior to actual payment, be subject to seizure or sequestration for the payment of any debts, judgments, alimony or separate maintenance owed by a Participant or any other person, nor be transferable by operation of law in the event of a Participant's or any other person's bankruptcy or insolvency.

Section 10.03

Validity and Severability. The invalidity or unenforceability of any provision of this Plan shall not affect the validity or enforceability of any other provision of this Plan, which shall remain in full force and effect, and any prohibition or unenforceability in any jurisdiction, shall not invalidate or render unenforceable such provision in any other jurisdiction.

Section 10.04

Governing Law. The validity, interpretation, construction and performance of this Plan shall in all respects be governed by the laws of the State of Missouri, without reference to principles of conflict of law, except to the extent preempted by federal law.

Section 10.05

Employment Status. This Plan does not constitute a contract of employment or impose on the Participant or the Company any obligation for the Participant to remain an employee of the Company or change the status of the Participant's employment or the policies of the Company and its affiliates regarding termination of employment.

Section 10.06

Underlying Incentive Plans and Programs. Nothing in this Plan shall prevent the Company from modifying, amending or terminating any Eligible Compensation arrangement or the incentive plans and programs pursuant to which cash awards are earned and which are deferred under this Plan.

Section 10.07

Code Section 409A. Notwithstanding any other provisions of the Plan or any Participation Agreement to the contrary, no payment shall be granted, deferred, accelerated, extended, made or modified under this Plan in a manner that would result in the imposition of an additional tax under Code Section 409A upon a Participant. In the event that it is reasonably determined by the Committee that, as a result of Code Section 409A, payments under the Plan may not be made at the time contemplated by the terms of the Plan or the relevant Participation Agreement, as the case may be, without causing the Participant receiving such payment to be subject to taxation under Code Section 409A, the Company will make such payment on the first day that would not result in the Participant incurring any tax liability under Code Section 409A; which, if the Participant is a Specified Employee within the meaning of the Code Section 409A, shall be the first day following the six-month period beginning on the date of Participant's termination of employment. The Company shall use commercially reasonable efforts to implement the provisions of this Section 10.07 in good faith; provided that neither the Company, the Committee nor any of the Company's employees, directors or representatives shall have any liability to a Participant with respect to this Section 10.07.

IN WITNESS WHEREOF, the Company has caused this Amendment and Restatement of the Plan to be executed by its duly authorized officer or representative.

CENTENE CORPORATION

By: /s/ Christopher A. Koster

APPENDIX A

Centene Corporation Common Stock (CNC)
MainStay VP U.S. Government Money Market - Initial Class
MFS® Value Series - Initial Class
Fidelity® VIP Index 500 Portfolio - Initial Class
Fidelity® VIP Growth Portfolio - Initial Class
Fidelity® VIP Contrafund® Portfolio - Initial Class
Janus Henderson VIT Enterprise Portfolio - Institutional Class
T. Rowe Price New America Growth Portfolio
T. Rowe Price International Stock Portfolio
PIMCO VIT Total Return Portfolio-Administrative Class Shares
Janus Henderson VIT Enterprise Portfolio - Institutional Class
T. Rowe Price Blue Chip Growth Portfolio
Lord Abbett Series - Mid-Cap Stock Portfolio - Class VC
VOYA Russell Mid Cap Index Portfolio - Initial Class
Delaware VIP® Small Cap Value Series - Standard Class
MainStay VP Eagle Small Cap Growth Portfolio - Initial Class
MainStay VP Small Cap Core - Initial Class
LVIP Baron Growth Opportunities Fund - Service Class
Delaware VIP Emerging Markets Series – Standard Class
Moody's Corporate Bond Average
Fidelity® VIP Freedom 2010 Portfolio - Initial Class
Fidelity® VIP Freedom 2020 Portfolio - Initial Class
Fidelity® VIP Freedom 2030 Portfolio - Initial Class
Fidelity® VIP Freedom 2040 Portfolio - Initial Class
Fidelity® VIP Freedom 2050 Portfolio - Initial Class

CENTENE CORPORATION
EXECUTIVE SEVERANCE AND CHANGE IN CONTROL PLAN
(and Summary Plan Description)
for Eligible Executives

I. PURPOSE

This Centene Corporation Executive Severance and Change in Control Plan (the "Executive Plan") is intended to provide benefits to eligible employees of Centene Corporation and its United States based subsidiaries (collectively, the "Company"), who become unemployed as a result of a Qualifying Termination, as described below. This Executive Plan is intended to comply with all applicable requirements of the Employee Retirement Income Security Act of 1974 ("ERISA") and the regulations promulgated thereunder for severance pay plans and is to be interpreted in a manner consistent with such requirements. This document contains the provisions of both the Executive Plan and the Summary Plan Description. This Executive Plan is adopted effective January 6, 2024, and, except as set forth in Section IX.E. of the Executive Plan, supersedes any and all previous severance pay policies, practices, plans and arrangements, whether written or oral, of the Company applicable to the Eligible Employee.

II. WHO IS ELIGIBLE TO PARTICIPATE

To be eligible to be a participant in this Executive Plan (an "Eligible Employee"), an individual must meet all the following qualifications at the time his/her employment terminates:

- A. The employee must be currently employed in the capacity of and holding the title or a level of Senior Vice President or above position within the Company or have otherwise been designated by the Company as a participant in the Executive Plan (i.e., Market or Business Unit CEO ("BU CEO"), Regional Vice Presidents or select Vice Presidents).
- B. The employee must be employed by the Company as a Full-Time Employee.
- C. The employee must be employed by an entity that is eligible to participate in this Executive Plan pursuant to a list of participating entities maintained by the Plan Administrator, which list may not be changed (other than to add additional entities) during the two-year period following a Change in Control.
- D. The employee must become a party to a restrictive covenant agreement in the form provided by the Company.
- E. The employee is not a party to an employment or severance agreement or offer letter with the Company that provides for severance payments (each, an "Individual Agreement") or, not later than 120 days following the effective date of this Executive Plan (or such longer period as determined by the Plan Administrator in its sole discretion), such individual agrees in writing that his or her existing rights under such Individual Agreement are terminated and replaced with the provisions of this Executive Plan.
- F. The employee must experience a Qualifying Termination, as set forth in Section IV, below.

III. DEFINITIONS

Words or phrases which are initially capitalized or within quotation marks shall have the meanings provided in this Section III and as provided elsewhere herein. For purposes of this Executive Plan, the following definitions apply:

- A. "Accrued Obligations" shall mean, as of the date of termination, (A) Eligible Employee's then-current Base Salary (disregarding any reduction constituting Good Reason) through the date of termination to the extent not theretofore paid, (B) any vacation pay, sick pay, and other paid time off earned and accrued by the Eligible Employee as of the date of termination to the extent not theretofore paid and to the extent payable upon the date of termination pursuant to the applicable Company policy, (C) any unpaid expenses incurred and reported in accordance with the Company's policies, and (D) vested benefits owing under any employee benefit plans of the Company and the Affiliates.
- B. "Affiliates" shall mean all corporations and other entities directly or indirectly controlling, controlled by or under common control with the Centene Corporation, where control may be by management authority, equity interest or otherwise; or any corporation or other entity in which the Company has a substantial

ownership interest, as determined by the Plan Administrator in its sole discretion, or with which the Company is a joint venturer or the like. Following a Change in Control, "Affiliate" shall include any entity that acquires Centene Corporation and its affiliated entities.

- C. "Cause" shall mean acts or omissions that the Company determines, after affording the Eligible Employee an opportunity to be heard, (i) are criminal, dishonest or fraudulent or constitute misconduct that reflects negatively on the reputation of the Company (including any parent, subsidiary, Affiliate or division of the Company); (ii) could expose the Company or any parent, subsidiary, Affiliate or division of the Company to claims of illegal harassment or discrimination in employment; (iii) are material breaches of this Executive Plan; or (iv) reflect continued and repeated failure to (A) perform substantially the duties of his/her employment (other than any such failure resulting from the Eligible Employee's physical or mental impairment or incapacity) or (B) to comply with any material written policy of the Company.
- D. "Change in Control" shall have the meaning set forth in the Centene Corporation 2012 Stock Incentive Plan or any successor plan thereto.
- E. "Change in Control Termination" shall mean a Qualifying Termination within twenty-four (24) months after the occurrence of a Change in Control (or during the six months prior to a Change in Control at the request of any third party participating in or causing the Change in Control).
- F. "Code" means the Internal Revenue Code of 1986, as amended, and the regulations promulgated thereunder.
- G. "Confidential Information" shall mean the Company's trade secrets and other non-public proprietary information relating to the Company or the business of the Company, including information relating to financial statements, customer lists and identities, potential customers, customer contacts, employee skills and compensation, employee data, suppliers, acquisition targets, servicing methods, equipment, programs, strategies and information, analyses, marketing plans and strategies, profit margins, financial, promotional, marketing, training or operational information, and other information developed or used by the Company that is not known generally to the public or the industry. Confidential Information shall not include any information that is in the public domain or becomes known in the public domain through no wrongful act on the part of Eligible Employee.
- H. "Disability" shall mean the disability of the Eligible Employee as defined in Section 409A(a)(2)(C) of the Code.
- I. "Full-Time Employee" shall mean an employee assigned to an established position with a regular work schedule of at least thirty (30) hours per week."
- J. "Good Reason" shall mean, without the Eligible Employee's prior written consent, at or after a Change in Control, (i) a reduction in Eligible Employee's annual Base Salary or annual target bonus opportunity from those in effect immediately prior to the Change in Control, (ii) a material reduction in Eligible Employee's authority, duties or responsibilities from those in effect immediately prior to the Change in Control, or (iii) a demand by the Company or the entity surviving the transaction that resulted in the Change in Control that Eligible Employee relocate to a primary work location more than fifty (50) miles from Eligible Employee's primary work location immediately prior to the Change in Control; provided that such proposed relocation results in a greater commute for Eligible Employee based on Eligible Employee's residence immediately prior to such relocation. Eligible Employee must provide written notice to the Company of the existence of Good Reason no later than 90 days after its initial existence, the Company shall have a period of 30 days following its receipt of such written notice during which it may remedy in all material respects the Good Reason condition identified in such written notice. If the Company fails to remedy in all material respects such Good Reason condition, the Eligible Employee shall have 90 days to terminate his/her employment for Good Reason.
- K. "Plan Administrator" shall mean the Compensation and Talent Committee of the Board of Directors of Centene Corporation or its delegate.
- L. "Restricted Period" shall mean 12 months for Tier I & Tier II Eligible Employees, and 9 months for Tier III Eligible Employees, in each case, following termination of employment for any reason.

IV. QUALIFYING EVENTS

Except as otherwise determined by the Company, a termination of employment is a “Qualifying Termination” only if all of the following requirements are met:

- A. The Eligible Employee is on the active payroll of the Company or on an approved leave of absence with guaranteed reinstatement at the time employment terminates;
- B. The termination occurs solely as a result of any of the following:
 - 1. The elimination of the Eligible Employee’s position with the Company in conjunction with a reduction-in-force or corporate restructuring;
 - 2. The Eligible Employee is involuntarily terminated without Cause (and other than due to death or Disability); or
 - 3. The Eligible Employee terminates his/her employment for Good Reason (applicable only to Change in Control Terminations);
- C. The Eligible Employee is not offered other employment with (i) the Company or one of the Affiliates, (ii) a successor of the Company or one of the Affiliates (a “Successor”) or (iii) a purchaser of some or all of the assets of the Company or any of the Affiliates (a “Purchaser”), provided that following a Change in Control, the Eligible Employee shall be deemed not to have been offered other employment if such employment would provide the Eligible Employee with grounds to terminate employment for Good Reason;
- D. The Eligible Employee continues employment until the termination date designated by the Company, as such date may be extended by the Company from time to time in its sole discretion, provided that, following a Change in Control, the Company shall not be permitted to require such employment for a period that exceeds 30 days following (i) in the case of Section IV.B(1) or (2) of this Executive Plan, the date that the Eligible Employee receives a notice of termination from the Company or an Affiliate, and (ii) in the case of Section IV.B(3) of this Executive Plan, the date that the Company’s period to remedy in all material respects the applicable Good Reason condition expires;
- E. During the period from the date the Eligible Employee receives notice of termination until the termination date (which period, in the event of a termination following a Change in Control, shall not exceed 30 days following the date that the Eligible Employee receives notice of termination), the Eligible Employee’s performance and conduct are reasonably in accordance with all material policies and procedures of the Company and are otherwise reasonably satisfactory to the Company;
- F. The Eligible Employee executes and delivers to the Company a general and full release of claims on a form that is then acceptable to the Company and with such other terms as the Company may then require (the “Employee Release”) (which Employee Release, in the event of a termination following a Change in Control, shall be reasonably consistent with the Employee Release utilized by the Company prior to the Change in Control), within the timeframe required by the Older Workers Benefit Protection Act or the timeframe provided by the Company, whichever is later, and, having signed the Employee Release, if a revocation right is afforded to the Eligible Employee, the Eligible Employee does not timely revoke it;
- G. The Eligible Employee fulfills, and agrees to continue to fulfill, all of his or her obligations, whether due to contract, statute or common law, to the Company and the Affiliates with respect to Confidential Information, non-disclosure, non-competition, and non-solicitation and with respect to such other obligations, as may from time to time be required by the Company, including but not limited to those restrictive covenants set forth in Section VIII; and
- H. The Eligible Employee timely delivers to the Company a resignation from all offices, directorships and fiduciary positions with the Company, the Affiliates and employee benefit plans.

V. SEVERANCE BENEFITS ABSENT A CHANGE IN CONTROL

An Eligible Employee who experiences a Qualifying Termination that is not a Change in Control Termination shall be entitled to the following (in addition to the Accrued Obligations):

A. SEVERANCE PAY

An Eligible Employee shall receive the following severance pay, payable in a lump sum within 74 days following his/her Qualifying Termination, provided that, to the extent necessary to avoid any taxes or penalties pursuant to Section 409A (as defined in Section IX.G), any portion of the following severance pay that constitutes deferred compensation within the meaning of Section 409A that was payable pursuant to an Individual Agreement shall be paid at the earliest date that is permitted in accordance with the schedule set forth in the Individual Agreement, as in effect on the date of termination of the Individual Agreement or at such time later time as required by Section IX.G:

Tier as of Termination Date	Cash Severance
Tier I Eligible Employee (EVP/SVP)	Prorated Target Bonus <i>plus</i> 1 x Base Salary
Tier II Eligible Employee (BU CEO)	Prorated Target Bonus <i>plus</i> 1 x Base Salary
Tier III Eligible Employee (Other)	Prorated Target Bonus <i>plus</i> .75x Base Salary

Base salary is equal to the Eligible Employee's annual base salary at the time of the Qualifying Termination ("Base Salary"). The prorated bonus shall be determined by multiplying the Eligible Employee's annual bonus at target by a fraction the numerator of which is the number of full months the Eligible Employee worked in the calendar year and the denominator of which is 12 (the "Prorated Target Bonus").

Amounts payable under this Section V.A shall be reduced by all taxes and other amounts which the Company is required to withhold under applicable law.

B. MEDICAL AND DENTAL BENEFITS

If the Eligible Employee has timely elected to continue his or her participation and, if applicable, that of his or her eligible dependents, in the Company's group health and dental plans under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), the Eligible Employee will be responsible to pay contributions for the health and dental insurance continuation coverage (collectively, "Medical Coverage") provided under this Section V.B in the same amount as is charged to similar active employees for similar coverage (and the Company shall pay the remainder of the COBRA premium amount) for the applicable period set forth below or, if earlier, until the date that the Eligible Employee becomes eligible for group health coverage from a subsequent employer.

Tier as of Termination Date	Medical and Dental Benefits
Tier I Eligible Employee (EVP/SVP)	12 months
Tier II Eligible Employee (BU CEO)	12 months
Tier III Eligible Employee (Other)	9 months

C. LONG TERM INCENTIVE AWARDS

Outstanding Company equity awards held by the Eligible Employee at the time of his/her Qualifying Termination shall continue to vest, and stock options and stock appreciation rights shall continue to be exercisable to the extent that their original terms have not then expired, for the number of months following the Qualifying Termination set forth below (and any stock options or stock appreciation rights that first become exercisable less than 90 days prior to the end of the equity continuation period below shall remain exercisable for 90 days following the date that they first become exercisable). For any performance-based restricted stock units ("PSUs") eligible to vest pursuant to the prior sentence, the level at which such PSUs are earned shall be based upon actual performance and be settled around the same time as PSUs are settled for the Company's officers generally. Except in the case of stock options and stock appreciation rights, any equity awards that become vested as set forth in this Section V.C shall be settled on the dates that they otherwise would have been settled in the event that the Eligible Employee's employment had continued until the applicable vesting date, subject to Section IX.G.

Tier as of Termination Date	Equity Continuation
Tier I Eligible Employee (EVP/SVP)	12 months
Tier II Eligible Employee (BU CEO)	12 months
Tier III Eligible Employee (Other)	9 months

Any unvested Cash Long-Term Incentive Plan ("CLTIP") awards outstanding at the time of the Qualifying Termination will be prorated (based on full months worked in the performance period) and will be earned based upon actual performance. Any such bonus amount shall be paid in a single, lump sum payment at the same time CLTIP awards for the applicable year are paid to the Company's officers generally. CLTIP awards that become vested as set forth in this Section V.C shall be settled on the dates that they otherwise would have been settled in the event that the Eligible Employee's employment had continued until the applicable vesting date, subject to Section IX.G.

D. OUTPLACEMENT ASSISTANCE

Assistance in the search for new employment will be provided to Eligible Employees who experience a Qualifying Termination, either through a state or local government agency or service or an outplacement firm for six months following the Qualifying Termination. The Company reserves the right to make the final decision as to the nature and extent of assistance to be provided and the designation or selection of the agency, service or outplacement firm.

VI. SEVERANCE BENEFITS IN CONNECTION WITH A CHANGE IN CONTROL

An Eligible Employee who experiences a Change in Control Termination shall be entitled to the following (in addition to the Accrued Obligations), in lieu of the severance benefits set forth in Section V:

A. SEVERANCE PAY

An Eligible Employee shall receive severance pay, payable in a lump sum within 74 days following his/her Qualifying Termination, provided that, to the extent necessary to avoid any taxes or penalties pursuant to Section 409A, any portion of the following severance pay that constitutes deferred compensation within the meaning of Section 409A that was payable pursuant to an Individual Agreement shall be paid at the earliest date that is permitted in accordance with the schedule set forth in the Individual Agreement, as in effect on the date of termination of the Individual Agreement or at such time later time as required by Section IX.G:

Tier as of Termination Date	Cash Severance
Tier I Eligible Employee (EVP/SVP)	2 x Base Salary <i>plus</i> 2 x Average Bonus
Tier II Eligible Employee (BU CEO)	1.5 x Base Salary <i>plus</i> 1.5 x Average Bonus
Tier III Eligible Employee (Other)	1 x Base Salary <i>plus</i> 1 x Average Bonus

“Average Bonus” is defined as the average of the last two (2) annual cash bonuses paid to the Eligible Employee (with any amounts deferred at the election of the Eligible Employee treated as having been paid to the Eligible Employee) in respect of the two (2) most recently completed full fiscal years of the Company for which bonuses have been paid prior to the date of termination (or if greater, prior to the Change in Control), provided that, in the case of an Eligible Employee who has not been employed by the Company for at least two (2) completed full fiscal years prior to the date of termination, such Eligible Employee’s annual bonus at target as of the date of termination shall be substituted for any fiscal year during which the Eligible Employee was not employed for the full fiscal year. Such amount will be paid in an undiscounted lump sum. In addition, the Eligible Employee will receive a prorated target annual bonus for the year in which such termination occurs, determined by multiplying the Eligible Employee’s annual bonus at target (disregarding any reduction in target bonus following the Change in Control) by a fraction the numerator of which is the number of full months the Eligible Employee worked in the calendar year and the denominator of which is 12.

In the event of a Change in Control Termination that occurs prior to a Change in Control, (i) the amounts payable pursuant to this Section VI.A shall be reduced by the amount of any cash severance or Prorated Target Bonus previously paid under Section V.A, and (ii) except as necessary to avoid any taxes or penalties pursuant to Section 409A and subject to Section IX.G, the additional cash severance payable pursuant to this Section VI.A shall be paid within 74 days following the Change in Control.

Benefits payable under this Section VI.A shall be reduced by all taxes and other amounts which the Company is required to withhold under applicable law and shall be payable as lump sum at one of the Company’s regular payroll periods and in accordance with its regular payroll practices.

B. MEDICAL, DENTAL AND LIFE INSURANCE BENEFITS

If the Eligible Employee is eligible to continue his or her participation, and that of his or her eligible dependents, in the Company’s group health and dental plans under COBRA, the Eligible Employee may exercise his or her right to do so in a timely manner. During the period of time specified below based on the Eligible Employee’s Tier as in effect on the date of termination, and during which the Eligible Employee has also timely elected Medical Coverage the Eligible Employee will be responsible to pay contributions for Medical Coverage provided under this Section VI.B in the same amount as is charged to similar active employees for similar coverage, rather than the full COBRA premium amount, and the Company shall pay the remainder of the COBRA premium amount for the applicable period set forth below or, if earlier, the date that the Eligible Employee becomes eligible for substantially comparable group health coverage from a subsequent employer.

Tier as of Termination Date	Medical and Dental Benefits
Tier I Eligible Employee (EVP/SVP)	18 months
Tier II Eligible Employee (BU CEO)	18 months
Tier III Eligible Employee (Other)	12 months

If the Company purchased a life insurance policy for the benefit of the Eligible Employee’s beneficiaries prior to the Change in Control, the Company will continue to maintain and pay all expenses associated with the corporate-owned life insurance policy for the remainder of Eligible Employee’s life. For purposes of calculating the amount of severance in this Section VI.B. due as a result of a Qualifying Termination, the Eligible Employee’s Base Salary and bonus amount at target will be based on the highest amount of such Base Salary and bonus amount at target during the two (2) year period ending on the date of termination.

C. LONG TERM INCENTIVE AWARDS

Any stock awards, stock options, stock appreciation rights or other equity-based awards or cash long-term incentive awards that are outstanding immediately prior to the Change in Control Termination shall, to the extent not then vested, fully vest and become exercisable as of the date of the Change in Control Termination (with any applicable performance goals deemed achieved at the greater of target level performance and actual performance in respect of the period prior to the Change in Control) and Eligible Employee shall have the right to exercise any such stock option, stock appreciation right, or other exercisable equity-based award until the earlier to occur of (i) one (1) year from the date of the Change in Control Termination and (ii) the expiration date of such stock option, stock appreciation right or other equity-based award as set forth in the agreement evidencing such award.

D. OUTPLACEMENT ASSISTANCE

Assistance in the search for new employment will be provided for Eligible Employees for six (6) months following the Change in Control Termination through an outplacement firm reasonably selected by the Company.

VII. TERMINATION OF BENEFITS

Notwithstanding anything to the contrary contained in this Executive Plan, severance pay and other benefits to which an Eligible Employee is entitled under Sections V or VI of this Executive Plan following a Qualifying Termination shall terminate upon the occurrence of the following circumstances:

- A. If the Eligible Employee accepts employment with the Company, one of the Affiliates, a Successor or a Purchaser, after qualifying for benefits under this Executive Plan, all such benefits will cease as of the date the Eligible Employee commences such employment.
- B. Prior to a Change in Control, all benefits under this Executive Plan may be terminated by the Company in the event that it determines, in its sole discretion, that the Eligible Employee has violated any obligation set forth in Sections IV or VIII of this Executive Plan.

VIII. RESTRICTIVE COVENANTS

The receipt of the benefits outlined in Section V and VI is conditioned on the Eligible Employee complying with the following:

- A. Non-Disclosure. Eligible Employee shall not, directly or indirectly, disclose to any competitor or other person or entity (other than current employees of the Company) any Confidential Information that Eligible Employee obtains while performing services for the Company, except as may be required to fulfill his/her duties to the Company or to comply with any applicable legal obligation.
- B. Non-Competition; Non-Solicitation.
 1. During Eligible Employee's employment with the Company and for the Restricted Period, Eligible Employee must adhere to the terms of any non-competition agreement or covenants entered into between the Eligible Employee and the Company or any of the Affiliates.
 2. During the Restricted Period, Eligible Employee will not, either directly or indirectly, either for himself or for any other person, firm, company or corporation, call upon, solicit, divert, or take away, or attempt to solicit, divert or take away any of the customers, prospective customers, business, vendors or suppliers of the Company or any Affiliate of the Company that Eligible Employee had dealings with, or responsibility for, or about which Eligible Employee had access to the Confidential Information or any customers', vendors' or suppliers' confidential information.
 3. Eligible Employee shall not, at any time during the Restricted Period, without the prior written consent of the Company, (a) directly or indirectly, solicit, recruit, hire, or employ (whether as an employee, officer, director, agent, consultant or independent contractor) any person who was or is at any time during the previous six (6) months an employee, representative, officer or director of the Company or any Affiliate of the Company; or (b) take any action to encourage or induce any employee, representative, contractor, consultant, vendor, officer or director of the Company or any Affiliate or division of the Company to cease their relationship with the Company or any Affiliate of the Company for any reason.

C. Remedies for Breach.

1. Because Eligible Employee's services are unique and because Eligible Employee has access to the Company's Confidential Information, any breach or threatened breach of this Section VIII will cause irreparable harm to the Company and that money damages alone would be an inadequate remedy, and in addition to all other rights and remedies available to it under this Executive Plan or otherwise, and whether in equity or at law, the Company may apply to any court of competent jurisdiction for specific performance and/or injunctive or other relief, without a bond, in order to enforce or prevent any violations of the provisions of this Section VIII.
2. Any breach of this Section VIII would also constitute a material breach of this Executive Plan and, the event of such a breach prior to a Change in Control, Eligible Employee will within 10 days after such breach repay any payments made and forfeit all payments to be made pursuant to Sections V or VI. The Company expressly reserves the right to pursue all other legal and equitable remedies available to it by virtue of any breach of this Section VIII, including without limitation injunctive relief.
3. The remedies provided for in this Section VIII are cumulative and not exclusive of any and other remedies available under this Executive Plan or otherwise, and whether in equity or at law. In that regard, while the forfeiture of payments and benefits referenced above (to the extent applicable) is appropriate in the event of a breach of this Section VIII, injunctive relief to prevent a continuing breach would still be necessary to give the Company an adequate remedy.

IX. GENERAL INFORMATION CONCERNING THE PLAN

- A. The Company pays the full cost of benefits provided under this Executive Plan from its general assets.
- B. Notwithstanding anything to the contrary contained herein, benefits shall be reduced by any other payments or benefits to which the Eligible Employee is entitled under applicable law as a result of termination of his/her employment, including without limitation any federal, state or local law with respect to plant closings, mass layoffs or group benefit plan continuation following termination or the like.
- C. Benefits under the Executive Plan are not assignable or subject to alienation. Likewise, benefits are not subject to attachments by creditors or through legal process against the Company, any of the Affiliates or any Eligible Employee.
- D. Notwithstanding anything to the contrary contained herein, any and all payments to be provided hereunder to or on behalf of any Eligible Employee are subject to reduction to the extent required by applicable statutes, regulations, rules and directives of federal, state and other governmental and regulatory bodies having jurisdiction over the Company or any of the Affiliates or a successor of the Company or any of the Affiliates.
- E. This Executive Plan does not constitute a contract of employment for a specific term or otherwise alter the at-will nature of the employment relationship between any Eligible Employee and the Company. An individual who is covered by an Individual Agreement with the Company will not be an Eligible Employee unless, not later than 120 days following the effective date of this Executive Plan (or such longer period as determined by the Plan Administrator in its sole discretion), such individual agrees in writing that his or her existing rights under such Individual Agreement are terminated and replaced with the provisions of this Executive Plan.
- F. The Company shall have the right to act for and on behalf of any or all of the Affiliates in all matters relating to the Executive Plan.

- G. The Executive Plan is intended to comply with, or be exempt from, the applicable requirements of Section 409A of the Code (“Section 409A”), and the Executive Plan will be interpreted on a basis consistent with such intent. Notwithstanding anything contained herein to the contrary, the Eligible Employee shall not be considered to have terminated employment with the Company for purposes of any payments under this Executive Plan which are subject to Section 409A until the Eligible Employee has incurred a “separation from service” from the Company within the meaning of Section 409A. Each amount to be paid or benefit to be provided under this Executive Plan shall be construed as a separate identified payment for purposes of Section 409A. Without limiting the foregoing and notwithstanding anything contained herein to the contrary, to the extent required in order to avoid an accelerated or additional tax under Section 409A, amounts that would otherwise be payable and benefits that would otherwise be provided pursuant to this Executive Plan during the six-month period immediately following the Eligible Employee’s separation from service shall instead be paid on the first business day after the date that is six months following the Eligible Employee’s separation from service (or, if earlier, the Eligible Employee’s date of death). To the extent required to avoid an accelerated or additional tax under Section 409A, amounts reimbursable to the Eligible Employee shall be paid to the Eligible Employee on or before the last day of the year following the year in which the expense was incurred and the amount of expenses eligible for reimbursement (and in-kind benefits provided to the Eligible Employee) during one year may not affect amounts reimbursable or provided in any subsequent year. In no event may an Eligible Employee, directly or indirectly, designate the calendar year of a payment, and in the event the period for executing the Employee Release overlaps two calendar years, severance benefits shall be paid in the second year to the extent required in order to avoid an accelerated or additional tax under Section 409A. The Company makes no representation that any or all of the payments described in this Executive Plan will be exempt from or comply with Section 409A and makes no undertaking to preclude Section 409A from applying to any such payment. This Section IX.G. shall not apply to payments for Medical Coverage under Sections V.B. or VI.B.
- H. Prior to a Change in Control (or, solely to the extent required by applicable law, following a Change in Control), benefits under the Executive Plan shall be subject to any applicable clawback policies or provisions adopted by the Company from time to time.
- I. In the case of any Eligible Employee that is a “disqualified individual” (as defined in Section 280G of the Code), the following provisions shall apply if any compensation, payment or distribution by the Company or any of its Affiliates to or for the benefit of such Eligible Employee, whether paid or payable or distributed or distributable pursuant to the terms of this Executive Plan or otherwise, calculated in a manner consistent with Section 280G of the Code (collectively, the “Parachute Payments”), would be subject to the excise tax imposed by Section 4999 of the Code or any interest or penalties with respect to such excise tax (such excise tax, together with any such interest and penalties, are collectively referred to as the “Excise Tax”), the following provisions shall apply:
1. If the Parachute Payments, reduced by the sum of the Excise Tax and the total of the federal, state, and local income and employment taxes (the “Income and Employment Taxes”) payable by such Eligible Employee on the amount of the Parachute Payments which are in excess of the Threshold Amount, are greater than or equal to the Threshold Amount, such Eligible Employee shall be entitled to the full Parachute Payments.
 2. If the Threshold Amount is less than (x) the Parachute Payments, but greater than (y) the Parachute Payments reduced by the sum of the Excise Tax and the Income and Employment Taxes on the amount of the Parachute Payments which are in excess of the Threshold Amount, then the Parachute Payments shall be reduced (but not below zero) to the extent necessary so that the sum of all Parachute Payments shall not exceed the Threshold Amount. In such event, the Parachute Payments shall be reduced in the following order to the extent applicable: (1) cash severance benefits not subject to Section 409A; (2) cash severance benefits subject to Section 409A; (3) cash-based long-term incentive awards subject to accelerated vesting upon a Qualifying Termination; (4) equity-based awards subject to accelerated vesting upon a Qualifying Termination; (5) non-cash benefits payable upon a Qualifying Termination, such as Medical Coverage and outplacement benefits; (6) cash awards payable automatically upon a Change in Control; and (7) equity-based awards payable automatically upon a Change in Control. If any reduced payment is made and through error or otherwise that payment exceeds the Threshold Amount, such Eligible Employee shall immediately repay such excess to the Company upon notification that any such overpayment has been made to the Eligible Employee.

3. For the purposes of this Section IX.I, “Threshold Amount” shall mean three times the Eligible Employee’s “base amount” within the meaning of Section 280G(b)(3) of the Code less one dollar (\$1.00). All determinations required to be made under this Section IX.I shall be made by an independent accounting firm retained by the Company prior to the date of Change in Control (the “Accounting Firm”), which shall provide detailed supporting calculations both to the Company and the Eligible Employee within fifteen (15) business days of the date of termination, or such earlier time as is requested by the Company. The Accounting Firm shall take into account any positions to mitigate any excise taxes payable under Section 4999 of the Code, such as the value of any reasonable compensation for services to be rendered by the Eligible Employee before or after the Change in Control, including any amounts payable to the Eligible Employee following termination of employment with respect to any restrictive covenants, and the Company shall cooperate in the valuation of any such services, including any non-competition provisions. Any determination by the Accounting Firm shall be binding upon the Company and the Eligible Employee.

X. ADMINISTRATION, CLAIMS PROCEDURE AND GENERAL INFORMATION

- A. The Company reserves the right to amend, modify and terminate this Executive Plan at any time by a written instrument signed by the Plan Administrator. Except as required by applicable law, any amendments, modifications or a termination of this Executive Plan that are adverse to the interests of an Eligible Employee will become effective in respect of such Eligible Employee on the one-year anniversary of the approved change. Furthermore, upon the occurrence of a Change in Control, no amendment, modification or termination shall become effective prior to the expiration of the two-year period after such Change in Control. There are no vested benefits under this Executive Plan. Also, the Plan Administrator reserves full discretion to administer the Executive Plan in all of its details, subject to the requirements of law. The Plan Administrator shall have such discretionary powers as are necessary to discharge its duties. The Plan Administrator may in its sole discretion delegate its discretion to the Company. Any interpretation or determination that the Plan Administrator makes regarding this Executive Plan, including without limitation determinations of eligibility, participation and benefits, including whether an employee qualifies as an Eligible Employee, are within the Plan Administrator’s sole and absolute discretion, and will be final, binding and conclusive, in the absence of clear and convincing evidence that the Plan Administrator acted arbitrarily and capriciously, provided that, following a Change in Control, any exercise of discretion must be made reasonably and in good faith.
- B. If you believe you are being denied any rights under the Executive Plans, you may file a claim in writing with the Plan Administrator. If your claim is denied, in whole or in part, the Plan Administrator will notify you in writing, giving the specific reasons for the decision, including specific reference to the pertinent Executive Plan provisions and a description of any additional material or information necessary to perfect your claim and an explanation of why such material or information is necessary. The written notice will also advise you of your right to request a review of your claim and the steps that need to be taken if you wish to submit your claim for review. If the Plan Administrator does not notify you of its decision within 90 days after it had received your claim (or within 180 days, if special circumstances exist requiring additional time, and if you had been given a written explanation for the extension within the initial-90-day claim period), you should consider your claim to have been denied. At this time you may request a review of the denial of your claim.
- C. A request for review must be made in writing by you or your duly authorized representative to the Plan Administrator, within 60 days after you have received the notice of denial. As part of your request, you may submit written issues and comments to the Plan Administrator, review pertinent documents, and request a hearing. The Plan Administrator’s written decision will be made within 60 days (or 120 days if a hearing is held or if other special circumstances exist requiring more than 60 days and written notice of the extension is provided to you within the initial 60-day period) after your request has been received. Again, the decision will include specific reasons including references to pertinent Executive Plan provisions.

- D. No legal action for benefits under the Executive Plan may be brought until the claimant (a) has submitted a written application for benefits in accordance with the procedures described by Paragraph B above, (b) has been notified by the Plan Administrator that the application is denied (or the application is deemed denied due to the Plan Administrator's failure to act on it within the established time period), (c) has filed a written request for a review of the application in accordance with the appeal procedure described in Paragraph C above and (d) has been notified in writing that the Plan Administrator has denied the appeal (or the appeal is deemed to be denied due to the Plan Administrator's failure to take any action on the claim within the time prescribed by Paragraph C above).
- E. As a participant in the Executive Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Executive Plan participants shall be entitled to:
1. Examine, without charge, at the Plan Administrator's office, all Executive Plan documents and copies of the documents filed by the Plan Administrator with the U.S. Department of Labor; and
 2. Obtain copies of these documents and other Executive Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

In addition to creating rights for Executive Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Executive Plan. The people who operate the Executive Plan, called "fiduciaries," have a duty to do so prudently and in the interest of Executive Plan participants. Neither the Company nor any other person may discriminate against an employee in any way to prevent him or her from obtaining benefits or exercising rights under ERISA. If a claim for benefits is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider the claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and you do not receive them within 30 days, a suit may be filed in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$ 110 a day until they are received, unless they were not sent due to reasons beyond the Plan Administrator's control. If you have a claim for benefits which is denied or not processed, in whole or in part, a suit may be pursued in a state or federal court, but if you file suit in state court, the suit may be removed to federal court. If you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If you are successful, the court may order the other party to pay these costs and fees. If you should lose, the court may order you to pay these costs and fees. Notwithstanding the foregoing, in any action brought by you following a Change in Control for damages or to enforce any provisions of this Executive Plan, if you prevail on at least one material issue, then the Company shall pay one hundred percent (100%) of all legal fees and expenses incurred by you in enforcing your rights pursuant to the Executive Plan. If you have any questions about the Executive Plan, you should contact the Plan Administrator. If there are any questions about this statement or about employee rights under ERISA, please contact the nearest area office of Pension and Welfare Benefits, U.S. Department of Labor.

- F. The Executive Plan is intended to constitute a "severance pay arrangement" within the meaning of Section 3(2)(B)(i) of ERISA so as to be excepted from the definitions of "employee pension benefit plan" and "pension plan" set forth under section 3(2) of ERISA, and is intended to meet the descriptive requirements of a plan constituting a "severance pay plan" within the meaning of regulations published by the Secretary of Labor at Title 29, Code of Federal Regulations § 2510.3-2(b). The Executive Plan is also intended to constitute an "unfunded welfare plan" maintained by the Company for the purpose of providing benefits for a select group of management or highly compensated employees such that it will be, among other things, exempt from the reporting and disclosure requirements of Part 1 of Title I of ERISA. In the event that the Executive Plan does not meet the requirements of a "severance pay arrangement" or an "unfunded welfare plan" as described above, the Executive Plan is intended to be "a plan which is unfunded and maintained by an employer primarily for the purpose of providing deferred compensation for a select group of management or highly compensation employees," within the meaning of Sections 201(2), 301(a)(3) and 401(a)(1) of ERISA.

G. The following information about this Executive Plan is provided in accordance with the applicable requirements of ERISA and the regulations promulgated thereunder:

Plan Sponsor Centene Corporation

Employer Identification Number of Plan Sponsor 39-1864073

Plan Number TBD

Plan Administrator The Compensation and Talent Committee of the Board of Directors of Centene Corporation

Type of Plan The Executive Plan is a severance pay plan.

Source of Funding The Executive Plan is unfunded; benefits are paid out of the general assets of the Company.

Plan Year January 1-December 31

Legal Process The agent for service of legal process with respect to the Executive Plan is:

Chief People Officer
Centene Corporation
7700 Forsyth Blvd., 8th Floor
St. Louis, MO 63105-3318

IN WITNESS WHEREOF, the Company has caused the Centene Corporation Executive Severance and Change in Control Plan to be duly executed under authority of its Board of Directors.

CENTENE CORPORATION
By: /s/ TANYA MCNALLY
Chief People Officer

Summary of Centene Corporation Executive Severance and Change in Control Plan

Termination due to a Qualifying Termination that is not a Change in Control Termination:

	Tier I (EVP/SVP)	Tier II (Market or Business Unit CEO)	Tier III (Other)
Severance (lump sum)	1x Base Salary	1x Base Salary	.75x Base Salary
Prorated Bonus	Prorated @ target	Prorated @ target	Prorated @ target
Equity (continued vesting)	12 months	12 months	9 months
Cash LTIP (if applicable)	Prorated @ actual performance	Prorated @ actual performance	Prorated @ actual performance
COBRA (Company subsidized)	12 months	12 months	9 months
Outplacement	6 months	6 months	6 months

Termination due to Qualifying Termination that is a Change in Control Termination:

	Tier I (EVP/SVP)	Tier II (Market or Business Unit CEO)	Tier III (Other)
Severance (lump sum)	2x Base Salary + 2x Average Bonus	1.5x Base Salary + 1.5x Average Bonus	1x Base Salary + 1x Average Bonus
Prorated Bonus	Prorated @ target	Prorated @ target	Prorated @ target
Equity (accelerated vesting)	All	All	All
Cash LTIP (if applicable)	Full vesting	Full vesting	Full vesting
COBRA (Company subsidized)	18 months	18 months	12 months
Outplacement	6 months	6 months	6 months

CENTENE CORPORATION
Restrictive Covenant Agreement
Pursuant to Executive Severance and Change in Control Plan

THIS AGREEMENT (“Agreement”) is entered into by Centene Corporation, a Delaware corporation (hereinafter the “Company”), and the undersigned employee of the Company or employee of one of Company’s Affiliates (hereinafter the “Participant”).

WHEREAS the Participant renders important services to the Company and/or its Affiliate(s), as defined in the Plan;

WHEREAS the services that Participant provides are critical to the continued success of the Company;

WHEREAS as the Company wishes to align its and Participant’s interest and as part of that effort Company has extended to Participant the ability to participate in the Company’s Executive Severance and Change in Control Plan, as in effect from time to time (“Plan”);

WHEREAS under the Plan, the Company is extending new, additional and substantial consideration which were unavailable to Participant before creation of the Plan;

WHEREAS as part of the ability to Participant to participate in the Plan and secure all the benefits contained therein, Participant has to agree to certain restrictive covenants and to waive and terminate Participant’s rights and all benefits pursuant to any prior Executive Severance and Change in Control Agreement to which the parties have agreed; and

WHEREAS the parties desire to further define and refine the obligations set out in the Plan.

NOW THEREFORE, in consideration of the foregoing and the benefits set out in the Plan, the parties hereto hereby agree as follows:

1. Participant’s Covenants.

As a material inducement to the Company extending Participant participation in, and the benefits of, the Plan, and in exchange for the Company providing Participant access to Company Confidential Information, Participant agrees to the following:

- a. **Non-Competition.** During Participant’s employment with the Company or any Affiliate of the Company, and for the Restricted Period as defined in the Plan, after the date Participant’s employment ends for any reason (whether voluntarily or involuntarily and whether with or without cause) (the “Termination Date”), Participant shall not, directly or indirectly, for Participant’s own benefit, or on behalf of any other person or entity, (x) become employed by or provide services to any Competitor in a Competing Position within the Restricted Area, or (y) become an owner or holder of any stock of other ownership interest in any Competitor, other than as an owner of less than 1% of the outstanding stock of a publicly traded company. For the purposes of this Section 1(a), the following definitions shall apply:

- i. The term “Competitor” means any person or business entity engaged in any area of business that is the same or substantially similar to any area(s) of business in which the Company and/or any of its Affiliates are engaged as of the Termination Date.
 - ii. The term Competing Position means a position involving job duties in any segment(s) or area(s) of the Competitor’s business that is the same or substantially similar to the segment(s) or area(s) of the Company’s or its Affiliates’ business (A) in which Participant was involved or had job duties at any time during the last 24 months of Participant’s employment, or (B) about which Participant learned Confidential Information at any time during the last 24 months of Participant’s employment.
 - iii. The term “Restricted Area” means any state in which the Company or any of its Affiliates conducts business and (A) in which Participant provided services in the last 24 months of Participant’s employment, or (B) about which Participant learned Confidential Information concerning the Company’s or its Affiliates’ business in such state in the last 24 months of Participant’s employment. Without limiting the foregoing, if Participant’s job duties in the last 24 months of employment materially involved duties pertaining to the business nationwide, the term “Restricted Area” means the entire United States.
 - iv. “Confidential Information” shall have the meaning set forth in the Plan.
- b. **State-Law Addendum: Modifications and Exceptions.** Notwithstanding the restrictions set forth above in this Section 1, if at the time of the offering of participation in the Plan, the Participant resides in a state listed in Exhibit A hereto, then the modifications and/or exceptions set forth for such state in Exhibit A shall apply to Participant. In addition, as a general matter, the Company will only seek to enforce this Agreement to the extent permitted under the applicable law of the state where Participant resided or worked for the Company at the time of the date Participant executed the Agreement. Furthermore, with respect to a Participant who is an attorney and employed by the Company or an Affiliate in his or her capacity as an attorney, Section 1(a) shall not apply to such Participant.
- c. **Change in Control.** In the event the Participant’s employment terminates because of a Change in Control Termination as defined in the Plan, the provisions of this Section 1(a) shall not apply.
- d. **Remedies for Breach.**
- i. Because the Participant’s services are unique and because the Participant has access to the Company’s Confidential Information, the parties agree that any breach or threatened breach of any of the terms of this Section 1 will cause irreparable harm to the Company and that money damages alone would be an inadequate remedy. The parties therefore agree that, in the event of any breach or threatened breach of this Section 1, and in addition to all other rights and

remedies available to it, the Company may apply to any court of competent jurisdiction for specific performance and/or injunctive or other relief, without a bond, in order to enforce or prevent any violations of the provisions of this Section 1.

- ii. In the event that the Company determines, in its sole discretion, that Participant has breached any of the terms of this Section 1 prior to a Change in Control, Participant will forfeit the right to any of the benefits to be made available pursuant to Section V of the Plan, and Company or an Affiliate shall be entitled to (x) recover the full value of any of the benefits already paid or made available to Participant within 10 days after such breach; and (y) not pay or make available to Participant benefits under the Plan that have not yet been paid or made available.
- iii. The rights and remedies set forth above shall be cumulative and in addition to any other rights or remedies to which the Company and its Affiliates may be entitled under any agreement or under the law.
- iv. Nothing in this Agreement, or any other agreement between the Participant and the Company or any of its Affiliates, or otherwise, limits the Participant's ability to communicate directly with and provide information, including documents, not otherwise protected from disclosure by any applicable law or privilege to the U.S. Securities and Exchange Commission (the "SEC") or any other federal, state, local or foreign governmental agency or commission ("Government Agency") regarding possible legal violations, without disclosure to the Company. The Company may not retaliate against the Participant for any of these activities, and nothing in this Agreement requires the Participant to waive any monetary award or other payment that the Participant might become entitled to from the SEC or any other Government Agency. Further, nothing in this Agreement precludes the Participant from filing a charge of discrimination with the U.S. Equal Employment Opportunity Commission or a like charge or complaint with a state or local fair employment practice agency. In addition, notwithstanding Participant's confidentiality obligations set forth in this Agreement or in the Plan, Participant understands that, pursuant to the U.S. Defend Trade Secrets Act of 2016, Participant will not be held criminally or civilly liable under any U.S. federal or state trade secret law for the disclosure of a trade secret that: (i) is made (A) in confidence to a federal, state, local or non-U.S. government official, either directly or indirectly, or to an attorney; and (B) solely for the purpose of reporting or investigating a suspected violation of law; or (ii) is made in a complaint or other document filed in a lawsuit or other proceeding, if such filing is made under seal. Participant also understands that if Participant files a lawsuit for retaliation by the Company for reporting a suspected violation of law, Participant may disclose the trade secret to Participant's attorney and use the trade secret information in the court proceeding, if Participant (x) files any document containing the trade secret under seal; and (y) does not disclose the trade secret, except pursuant to court order. Participant understands that if a disclosure of trade secrets was not done in good faith pursuant to the above, then

Participant may be subject to liability, including, without limitation, punitive damages and attorneys' fees.

- e. **Survival of Obligations.** The provisions of this Section 1 shall survive and continue in full force in accordance with their terms notwithstanding any termination or expiration of the Participant's employment for any reason.

2. Miscellaneous.

- a. **Severability.** The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement, and each other provision of this Agreement shall be severable and enforceable to the extent permitted by law. If a court of competent jurisdiction should determine that any of the geographic, durational or other provisions of Section 1 of this Agreement are overbroad or otherwise unenforceable because of the scope of such provisions, to the extent allowed by law, such court shall modify such provisions in a manner to render them enforceable, and such provisions, as may be modified, shall be fully enforceable as though set forth herein. Any such modification shall not affect the other provisions or clauses of this Agreement in any respect.
- b. **No Contract of Employment.** This Agreement does not constitute a contract of employment or contract of employment for a term, and the Participant remains at all times an employee-at-will.
- c. **Waiver.** Any provision for the benefit of the Company contained in this Agreement may be waived, either generally or in any particular instance, by the Board of Directors of the Company or a duly authorized committee or officer thereof.
- d. **Binding Effect.** This Agreement shall be binding upon and inure to the benefit of the Company and the Participant and their respective heirs, executors, administrators, legal representatives, successors and assigns.
- e. **Third Party Beneficiaries.** Participant acknowledges that any Affiliate to which Participant provides services, or about which Participant learns Confidential Information, shall be a third-party beneficiary of Participant's obligations under this Agreement. As such, each such Affiliate shall be permitted to enforce any of the terms of Section 1 of this Agreement against Participant as if such Affiliate were the Company (whether alone or jointly with the Company).
- f. **Notice.** Any notices hereunder shall be in writing and deemed effectively given upon personal delivery or five days after delivery to a United States Post Office, by registered or certified mail, postage prepaid, addressed to the other party hereto at (x) in the case of the Participant, at the last known address on file with Company or its Affiliate; and (y) in the case of the Company, to Centene Company, 7700 Forsyth Blvd, Clayton, MO, 63105 attn: General Counsel.

- g. **Entire Agreement.** This Agreement and the Plan constitute the entire agreement between the parties, and supersede and replace (x) any and all previous severance pay policies, practices, plans and arrangements, whether written or oral, relating to the Participant including any prior Executive Severance and Change in Control Agreement to which the parties have agreed, and the Participant hereby waives and terminates the Participant's rights and all benefits thereunder; and (y) the Participants' noncompetition obligations in any other agreement with the Company or its Affiliates.
- h. **Participant's Acknowledgments.** The Participant acknowledges that he or she: (i) has read this Agreement; (ii) has obtained the advice of an attorney of Participant's own choosing or has voluntarily declined to seek such counsel; (iii) understands the terms and consequences of this Agreement; and (iv) is fully aware of the legal and binding effect of this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement.

CENTENE
CORPORATION

By: /s/ TANYA
MCNALLY
Chief People
Officer

Exhibit A

State Law Addendum:

Modifications and Exceptions to Restrictions in Restrictive Covenant Agreement

If Participant is a resident of one of the following states as of the date Employee executes this Restricted Covenant Agreement (“Effective Date”) (to which this Exhibit A is attached) (the “Agreement”), the following exceptions and acknowledgments applicable to such state shall apply to Participant, notwithstanding anything to the contrary in this Agreement or the Plan:

****ARKANSAS.** If Participant is a resident of Arkansas as of the Effective Date and Participant is a person holding a professional license under Arkansas Code Title 17, Subtitle 3, Section 1(a) will not apply to Participant.

****CALIFORNIA.** If Participant is a resident of California as of the Effective Date:

Section 1(a) will only apply to Participant during Participant’s employment. In addition, California law shall apply to Participant’s rights and obligations under the Agreement and, unless preempted by federal law, under the Plan.

****COLORADO.** If Participant is a resident of Colorado as of the Effective Date: (1) Participant acknowledges that Participant was provided a copy of this Restrictive Covenant Agreement at least 14 days before the earlier of the effective date of the RSU Agreement and Sections 1(a) and (b) contained therein; and (2) Colorado law shall apply to Participant’s rights and obligations under Section 10 of the RSU Agreement.

****DISTRICT OF COLUMBIA.** If Participant is a resident of the District of Columbia as of the Effective Date: (1) Participant acknowledges that Participant was provided a copy of this Agreement at least 14 days before the Participant must accept and execute the Agreement; and (2) the Company provides the following notice to Participant: The District of Columbia's Ban on Non-Compete Agreements Amendment Act of 2020 limits the use of non-compete agreements. It allows employers to request non-compete agreements from highly compensated employees, as that term is defined in the Ban on Non-Compete Agreements Amendment Act of 2020, under certain conditions. Centene has determined that you are a highly compensated employee. For more information about the Ban on Non-Compete Agreements Amendment Act of 2020, contact the District of Columbia Department of Employment Services (DOES).

****ILLINOIS.** If Participant is a resident of Illinois as of the Effective Date: (1) Participant shall have at least 14 calendar days to review and consider this Agreement from the date Participant received this document; provided, however, Participant is permitted to accept this Award before the expiration of the foregoing 14-day period; and (2) the Company hereby advises Participant to consult with an attorney prior to accepting and entering into the Agreement (however, any such legal consultation shall be at Participant’s own expense).

****LOUISIANA.** If Participant is a resident of Louisiana as of the Effective Date, after the termination of Participant’s employment Sections 1(a) and 1(b) shall apply only in the following parishes in the State of Louisiana: Acadia, Allen, Ascension, Assumption, Avoyelles, Beauregard, Bienville, Bossier, Caddo, Calcasieu, Caldwell, Cameron, Catahoula, Claiborne, Concordia, De Soto, East Baton Rouge, East Carroll, East Feliciana, Evangeline, Franklin, Grant, Iberia, Iberville, Jackson, Jefferson, Jefferson Davis, La Salle, Lafayette, Lafourche, Lincoln, Livingston, Madison, Morehouse, Natchitoches, Orleans,

Ouachita, Plaquemines, Pointe Coupee, Rapides, Red River, Richland, Sabine, St. Bernard, St. Charles, St. Helena, St. James, St. John The Baptist, St. Landry, St. Martin, St. Mary, St. Tammany, Tangipahoa, Tensas, Terrebonne, Union, Vermilion, Vernon, Washington, Webster, West Baton Rouge, West Carroll, West Feliciana, and Winn.

****MAINE.** If Participant is a resident of Maine as of the Effective Date: (1) the terms of Section 1(a) of this Agreement regarding Participant's post-termination obligations do not take effect until the later of (a) one (1) year of Participant's employment with the Company or (b) a period of six (6) months from the date that Participant accepted the RSU Agreement; (2) Participant acknowledges that Participant was provided with at least 3 days to review this Agreement from the date Participant received the Award document; provided, however, that Participant is permitted to accept this Agreement earlier than the expiration of such (3) day review period.

****MASSACHUSETTS.** If Participant is a resident of Massachusetts as of the Effective Date: (1) Participant acknowledges that Participant was provided with at least 10 business days to review this Agreement from the date Participant received this document; provided, however, Participant is permitted to accept this Agreement earlier than the expiration of such 10 day review period; (2) Participant understands that Participant has the right to consult with an attorney prior to accepting the Agreement, but that any legal consultation is at Participant's own expense; (3) Participant acknowledges that Participant has had an adequate opportunity to consult with an attorney, Participant has read and understands this Agreement, and is voluntarily accepting the Agreement; (4) the terms of this Agreement, including the benefits of the Plan , are being provided as consideration for Participant's agreement to the restrictions in Section 1(a) of the Agreement; (5) Section 1(a) will not apply if Participant is terminated without cause or laid off, unless the Parties enter into a separation or severance agreement, pursuant to which Participant receives severance pay (in which case the non-compete restriction in Section 1(a) shall be limited to the duration of the severance pay).

****MINNESOTA.** If Participant is a resident of Minnesota as of the Effective Date, Section 1(a) will only apply to Participant during Participant's employment. In addition, Minnesota law shall apply to Participant's rights and obligations under Section 1 of the Agreement.

****NEBRASKA.** If Participant is a resident of Nebraska as of the Effective Date, Section 1(a) will not apply after the termination of Participant's employment.

****NEVADA.** If Participant is a resident of Nevada as of the Effective Date: (1) after the termination of Participant's employment Sections 1(a) and 1(b) will not prohibit Participant from providing service to a former provider or customer of the Company if Participant can demonstrate that (a) Participant did not solicit the former provider or customer, (b) the former provider or customer voluntarily chose to leave the Company and seek services from Participant, and (c) Participant is otherwise complying with the limitations in this Agreement other than any limitation on providing services to a former provider or customer who seeks the services of Participant without any contact instigated by Participant; and (2) if Participant's employment is terminated as a result of a reduction of force, reorganization, or similar restructuring, Section 1(a) will only apply during the period Company is paying the Participant's salary, benefits, or equivalent compensation including, without limitation, severance pay.

****NORTH DAKOTA.** If Participant is a resident of North Dakota as of the Effective Date, Sections 1(a) and 1(b) will apply to Participant only during Participant's employment and will not apply after Participant's employment ends.

****OKLAHOMA.** If Participant is a resident of Oklahoma as of the Effective Date: (1) Section 1(a) will not apply after the termination of Participant's employment; and (2) Section 1(b) with respect to providers and customers, will apply after Participant's employment only with respect to providers or customers of the Company that are "established customers" of the Company per Okla. Stat. Ann. tit. 15, § 219A.

****OREGON.** If Participant is a resident of Oregon as of the Agreement Date: (1) Participant acknowledges that Participant was provided with at least two weeks to review this Agreement and that accepting this Agreement before the expiration of this two week period shall serve as a waiver of the two week review period; and (2) Participant acknowledges that the benefits set out in the Plan constitutes consideration for the Agreement.

List of Subsidiaries as of December 31, 2023

ABC Network & Collaborative Health Systems Joint Venture, LLC, an Arizona LLC
 Absolute Total Care, Inc, a South Carolina corporation
 AcariaHealth Pharmacy #11, Inc, a Texas corporation
 AcariaHealth Pharmacy #12, Inc, a New York corporation
 AcariaHealth Pharmacy #13, Inc, a California corporation
 AcariaHealth Pharmacy #14, Inc, a California corporation
 AcariaHealth Pharmacy #26, Inc, a Delaware corporation
 AcariaHealth Pharmacy, Inc, a California corporation
 AcariaHealth, Inc., a Delaware corporation
 Access Medical Acquisition, LLC, a Delaware LLC
 Access Medical Group of Florida City, LLC, a Florida LLC
 Access Medical Group of Hialeah, LLC, a Florida LLC
 Access Medical Group of Kendall, LLC, a Florida LLC
 Access Medical Group of Lakeland, LLC, a Florida LLC
 Access Medical Group of Lauderdale Lakes, LLC, a Florida LLC
 Access Medical Group of Margate, LLC, a Florida LLC
 Access Medical Group of Miami, LLC, a Florida LLC
 Access Medical Group of North Miami Beach, LLC, a Florida LLC
 Access Medical Group of Opa-Locka, LLC, a Florida LLC
 Access Medical Group of Pembroke Pines, LLC, a Florida LLC
 Access Medical Group of Perrine, LLC, a Florida LLC
 Access Medical Group of Riverview, LLC, a Florida LLC
 Access Medical Group of Tampa II, LLC, a Florida LLC
 Access Medical Group of Tampa III, LLC, a Florida LLC
 Access Medical Group of Tampa, LLC, a Florida LLC
 Access Medical Group of Westchester, LLC, a Florida LLC
 Accountable Care Coalition Direct Contracting, LLC, a Florida LLC
 Accountable Care Coalition of Georgia, LLC, a Georgia LLC
 Accountable Care Coalition of Northeast Partners, LLC, a Pennsylvania LLC
 Accountable Care Coalition of Quality Health II, LLC, a Delaware LLC
 Accountable Care Coalition of Southeast Texas, Inc., a Texas corporation
 Accountable Care Coalition of Southeast Wisconsin, LLC, a Wisconsin LLC
 Agate Resources, Inc., an Oregon corporation
 Ambetter Health of Louisiana, Inc., a Louisiana corporation
 Ambetter of Magnolia, Inc, a Mississippi corporation
 Ambetter of North Carolina, Inc., a North Carolina corporation
 Ambetter of Peach State Inc., a Georgia corporation
 American Progressive Life and Health Insurance Company of New York, a New York corporation
 America's 1st Choice California Holdings, LLC, a Florida corporation
 Ardan TacOpps I, LLC, a Delaware LLC
 Arizona Biodyne, Inc., an Arizona corporation
 Arkansas Health & Wellness Health Plan, Inc., an Arkansas corporation
 Arkansas Total Care, Inc., an Arkansas corporation
 Armed Forces Services Corporation, a Virginia corporation
 Aurelia Health, LLC, an Arizona corporation
 Bankers Reserve Life Insurance Company of Wisconsin, a Wisconsin corporation

Bishopswood SPV Limited, an English and Welsh private company
BMI Imaging Clinic Limited, an English and Welsh private company
BMI Southend Private Hospital Limited, an English and Welsh private company
BMI Syon Clinic Limited, an English and Welsh private company
Bridgeway Health Solutions of Arizona, Inc., an Arizona corporation
Bridgeway Health Solutions, LLC, a Delaware LLC
Buckeye Community Health Plan, Inc, an Ohio corporation
Buckeye Health Plan Community Solutions, Inc., an Ohio corporation
California Health and Wellness Plan, a California corporation
Cantina Laredo Clayton, LP, a Delaware limited partnership
Care 1st Health Plan Administrative Services, Inc., an Arizona corporation
Care 1st Health Plan of Arizona, Inc., an Arizona corporation
Carolina Complete Health Holding Company Partnership, a Delaware partnership
Carolina Complete Health, Inc., a North Carolina corporation
Celtic Group, Inc, a Delaware corporation
Celtic Insurance Company, an Illinois corporation
Cenpatico Behavioral Health, LLC, a California LLC
Centene Center I, LLC, a Delaware LLC
Centene Center II, LLC, a Delaware LLC
Centene Center LLC, a Delaware LLC
Centene Health Plan Holdings, Inc., a Delaware corporation
Centene Institute for Advanced Health Education, LLC, a Delaware LLC
Centene International Financing Company Limited, a limited liability Malta company
Centene International Ventures, LLC, a Delaware LLC
Centene Management Company LLC, a Wisconsin LLC
Centene Pharmacy Services, Inc., a Delaware corporation
Centene Venture Company Alabama Health Plan, Inc., an Alabama corporation
Centene Venture Company Florida, Inc., a Florida corporation
Centene Venture Company Illinois, Inc., an Illinois corporation
Centene Venture Company Indiana, Inc., an Indiana corporation
Centene Venture Company Kansas, Inc., a Kansas corporation
Centene Venture Company Michigan, Inc., a Michigan corporation
Centene Venture Company Tennessee, Inc., a Tennessee corporation
Centene Venture Insurance Company Texas, Inc., a Texas corporation
CHG Management Services Limited, an English and Welsh private company
Circle Birmingham Limited, an English and Welsh private company
Circle Clinical Services Limited, an English and Welsh private company
Circle Decontamination Limited, an English and Welsh private company
Circle Harmony Health Limited, a Hong Kong private company
Circle Harmony Health Limited, an English and Welsh private company
Circle Health 1 Limited, an English and Welsh private company
Circle Health 2 Limited, an English and Welsh private company
Circle Health 3 Limited, an English and Welsh private company
Circle Health 4 Limited, an English and Welsh private company
Circle Health Group Limited, an English and Welsh private company
Circle Health Holdings Limited, an English and Welsh private company
Circle Health MyWay Limited, an English and Welsh private company
Circle Holdings Limited, a Jersey private company
Circle Hospital (Reading) Limited, an English and Welsh private company

Circle International PLC, an English and Welsh PLC
Circle Nottingham Limited, an English and Welsh private company
Circle Rehabilitation Services, an English and Welsh private company
CMC Real Estate Company, LLC, a Delaware LLC
Cobalt Therapeutics, LLC, a Delaware LLC
Collaborative Choice Healthcare, LLC, a Delaware LLC
Collaborative Health IPA of Texas, LLC, a Texas LLC
Collaborative Health Systems IPA, LLC, a Florida LLC
Collaborative Health Systems of Maryland, LLC, a Maryland LLC
Collaborative Health Systems of New Mexico, LLC, a New Mexico LLC
Collaborative Health Systems of Virginia, LLC, a Virginia LLC
Collaborative Health Systems, LLC, a New York LLC
Community Medical Holdings Corp, a Delaware corporation
Comprehensive Health Management, LLC, a Florida LLC
Connecticut Value-Based Care Venture, LLC, a Connecticut LLC
Coordinated Care Corporation, an Indiana corporation
Coordinated Care of Washington, Inc, a Washington corporation
Delaware First Health Complete, Inc., a Delaware corporation
Delaware First Health, Inc., a Delaware corporation
DeNova Collaborative Health, LLC, an Arizona LLC
District Community Care Inc., a Washington D.C. corporation
Envolve Benefits Options, Inc., a Delaware corporation
Envolve Dental IPA of New York, Inc., a New York corporation
Envolve Dental of Florida, Inc., a Florida corporation
Envolve Dental of Texas, Inc., a Texas corporation
Envolve Dental, Inc., a Delaware corporation
Envolve Holdings, LLC, a Delaware LLC
Envolve Pharmacy IPA, LLC, a New York LLC
Envolve Total Vision, Inc., a Delaware corporation
Envolve Vision Benefits, Inc., a Delaware corporation
Envolve Vision IPA of New York, Inc., a New York corporation
Envolve Vision of Florida, Inc., a Florida corporation
Envolve Vision of Texas, Inc., a Texas corporation
Envolve Vision, Inc., a Delaware corporation
Envolve, Inc., a Delaware corporation
Essential Care Partners, LLC, a Texas LLC
Foundation Care, LLC, a Missouri LLC
General Healthcare Group Limited, an English and Welsh private company
General Healthcare Holdings 2 Limited, an English and Welsh private company
General Healthcare Holdings 3 Limited, an English and Welsh private company
Generale de Sante International Limited, an English and Welsh private company
GHG (DB) Pension Trustees, an English and Welsh private company
GHG Healthcare Holdings Limited, an English and Welsh private company
GHG Intermediate Holdings Limited, an English and Welsh private company
GHG Leasing Limited, an English and Welsh private company
GHG Mount Alvernia Hospital Limited, an English and Welsh private company
Golden Triangle Physician Alliance, a Texas not-for-profit corporation
Granite State Health Plan, Inc, a New Hampshire corporation
Hallmark Life Insurance Co, an Arizona corporation

Harmony Health Plan, Inc., an Illinois corporation
Harmony Health Systems Inc., a New Jersey corporation
Health Care Enterprises, LLC, a Delaware LLC
Health Net Access, Inc., an Arizona corporation
Health Net Community Solutions of Arizona, Inc., an Arizona corporation
Health Net Community Solutions, Inc., a California corporation
Health Net Federal Services, LLC, a Delaware LLC
Health Net Health Plan of Oregon, Inc., an Oregon corporation
Health Net Life Insurance Company, a California corporation
Health Net Life Reinsurance Company, a Cayman Islands corporation
Health Net of Arizona, Inc., an Arizona corporation
Health Net of California, Inc., a California corporation
Health Net, LLC, a Delaware LLC
Health Plan Real Estate Holdings, Inc., a Missouri corporation
Healthy Louisiana Holdings LLC, a Delaware LLC
Healthy Missouri Holdings, Inc, a Missouri corporation
Healthy Washington Holdings, Inc, a Delaware corporation
Heritage Health Systems of Texas, Inc., a Texas corporation
Heritage Health Systems, Inc., a Texas corporation
Heritage Physician Networks, a Texas not-for-profit corporation
HHS Texas Management, Inc., a Texas corporation
HHS Texas Management, LP, a Texas limited partnership
HLM Strategic Investment Fund, L.P., a Delaware limited partnership
Home State Health Plan, Inc, a Missouri corporation
HomeScripts.com, LLC, a Michigan LLC
Human Affairs International of California, a California corporation
Illinois Health Practice Alliance, LLC, a Delaware corporation
Integrated Mental Health Services, a Texas corporation
Interpreta Holdings, Inc., a Delaware corporation
Interpreta, Inc., a Delaware corporation
Iowa Total Care, Inc, an Iowa corporation
LifeShare Management Group, LLC, a New Hampshire LLC
Louisiana Healthcare Connections, Inc, a Louisiana corporation
Magellan Behavioral Care of Iowa, Inc., an Iowa corporation
Magellan Behavioral Health of Florida, Inc., a Florida corporation
Magellan Behavioral Health of New Jersey, LLC, a New Jersey LLC
Magellan Behavioral Health of Pennsylvania, Inc., a Pennsylvania corporation
Magellan Behavioral Health Systems, LLC, a Utah LLC
Magellan Behavioral of Michigan, Inc., a Michigan corporation
Magellan Capital, LLC, a Nevada LLC
Magellan Cares Foundation, Inc., a Delaware corporation
Magellan Complete Care of Louisiana, Inc., a Louisiana corporation
Magellan Complete Care of Pennsylvania, Inc., a Pennsylvania corporation
Magellan Financial Capital, LLC, a Delaware LLC
Magellan Health Q10, LLC, a Nebraska LLC
Magellan Health Services of Arizona, Inc., an Arizona corporation
Magellan Health Services of California, Inc. - Employer Services, a California corporation
Magellan Health Services of New Mexico, Inc., a New Mexico corporation
Magellan Health, Inc, a Delaware corporation

Magellan Healthcare Provider Group, Inc., a Maryland corporation
Magellan Healthcare, Inc., a Delaware corporation
Magellan HRSC, Inc., an Ohio corporation
Magellan Life Insurance Company, a Delaware corporation
Magellan of Georgia, Inc., a Georgia corporation
Magellan of Idaho, LLC, an Idaho LLC
Magellan of Maryland, LLC, a Maryland LLC
Magellan of Nevada, LLC, a Nevada LLC
Magellan Pharmacy Services, Inc., a Delaware corporation
Magellan Providers of Texas, Inc., a Texas corporation
Magnolia Health Plan, Inc, a Mississippi corporation
Magnolia Joint Venture Holding Company, Inc., a Delaware corporation
Managed Health Network, a California corporation
Managed Health Network, LLC, a Delaware LLC
Managed Health Services Insurance Corporation, a Wisconsin corporation
Maryland Collaborative Care Transformation Organization, Inc., a Delaware corporation
Maui Ola Health and Wellness, Inc., a Hawaii corporation
Meriden Hospital Advanced Imaging Centre Ltd., an English and Welsh private company
Meridian Health Plan of Illinois, Inc., an Illinois corporation
Meridian Health Plan of Michigan, Inc., a Michigan corporation
Meridian Management Company, LLC (a/k/a Meridian Administration Company, LLC), a Michigan LLC
Meridian Network Services, LLC, a Michigan LLC
MeridianRx IPA, LLC, a New York LLC
MeridianRx of Indiana, LLC, a Michigan LLC
MeridianRx, LLC, a Michigan LLC
Merit Behavioral Care Corporation, a Delaware corporation
MH Services International Holdings (UK) Limited, an English and Welsh private company
MHN Government Services LLC, a Delaware LLC
MHN Services, LLC, a California LLC
MHS Consulting, International, Inc, a Delaware corporation
Mid-Atlantic Collaborative Care, LLC, a Maryland LLC
Mount Alvernia PET CT Limited, an English and Welsh private company
Nations Healthcare Limited, an English and Welsh private company
Nebraska Total Care, Inc., a Nebraska corporation
Network Providers, LLC, a Delaware LLC
New York Quality Healthcare Corporation, a New York corporation
Next Door Neighbors, Inc., a Delaware corporation
Next Door Neighbors, LLC., a Delaware LLC
North West Cancer Clinic Limited, an English and Welsh private company
Novasys Health, Inc, a Delaware corporation
Ohana Health Plan, Inc., a Hawaii corporation
Oklahoma Complete Health Holding Company, LLC, a Delaware LLC
Oklahoma Complete Health Inc., an Oklahoma corporation
One Care by Care 1st Health Plans of Arizona, Inc., an Arizona corporation
P.P.C., Inc., a Missouri corporation
Peach State Health Plan, Inc, a Georgia corporation
Penn Marketing America, LLC, a Delaware LLC
Pennsylvania Health and Wellness, Inc., a Pennsylvania corporation
PPC Group, Inc., a Delaware corporation

Premier Marketing Group, LLC, a Delaware LLC
Presonyx, Inc., a Delaware corporation
QCA Health Plan, Inc., an Arkansas corporation
Qualchoice Life and Health Insurance Company, an Arkansas company
Quincy Coverage Corporation, a New York corporation
Rhythm Health Tennessee, Inc., a Tennessee corporation
RI Health & Wellness, Inc., a Rhode Island corporation
Runnymede SPV Limited, an English and Welsh private company
SelectCare of Texas, Inc., a Texas corporation
Shanghai Circle Harmony Hospital Management, a Chinese private company
SilverSummit Healthplan, Inc., a Nevada corporation
Social Health Bridge Trust, a Delaware trust
Social Health Bridge, LLC, a Delaware LLC
Specialty Therapeutic Care Holdings, LLC, a Delaware LLC
Specialty Therapeutic Care, GP, LLC, a Texas LLC
Specialty Therapeutic Care, LP, a Texas limited partnership
Sunflower State Health Plan, Inc, a Kansas corporation
Sunshine Health Community Solutions, Inc., a Florida corporation
Sunshine Health Holding LLC, a Florida LLC
Sunshine State Health Plan, Inc, a Florida corporation
Superior Health Management Advisors, LLC
Superior HealthPlan, Inc, a Texas corporation
The Pavilion Clinic Ltd, an English and Welsh private company
The WellCare Management Group, Inc., a New York corporation
Three Shires Hospital LP, an English and Welsh limited partnership
TKH Holding Ltd., an English and Welsh private company
Transplant Health Solutions IPA, Inc., a New York corporation
Trillium Community Health Plan, Inc., an Oregon corporation
U.S. IPA Providers, Inc., a New York corporation
UAM Agent Services Corp., an Iowa corporation
Universal American Corp., a Delaware corporation
Universal American Financial Services, Inc., a Delaware corporation
Universal American Holdings, LLC, a Delaware LLC
WCG Health Management, Inc., a Delaware corporation
WellCare Health Insurance Company of America, an Arkansas corporation
WellCare Health Insurance Company of Kentucky, Inc., a Kentucky corporation
WellCare Health Insurance Company of Louisiana, Inc., a Louisiana corporation
WellCare Health Insurance Company of Nevada, Inc., a Nevada corporation
WellCare Health Insurance Company of New Hampshire, Inc., a New Hampshire corporation
WellCare Health Insurance Company of New Jersey, Inc., a New Jersey corporation
WellCare Health Insurance Company of Oklahoma, Inc., an Oklahoma corporation
WellCare Health Insurance Company of Washington, Inc., a Washington corporation
WellCare Health Insurance of Arizona, Inc., an Arizona corporation
WellCare Health Insurance of Connecticut, Inc., a Connecticut corporation
WellCare Health Insurance of Hawaii, Inc., a Hawaii corporation
WellCare Health Insurance of New York, Inc., a New York corporation
WellCare Health Insurance of North Carolina, Inc., a North Carolina corporation
WellCare Health Insurance of Tennessee, Inc., a Tennessee corporation
WellCare Health Insurance of the Southwest, Inc., an Arizona corporation

WellCare Health Plans of Kentucky, Inc., a Kentucky corporation
WellCare Health Plans of Massachusetts, Inc, a Massachusetts corporation
WellCare Health Plans of Missouri, Inc., a Missouri corporation
WellCare Health Plans of New Jersey, Inc., a New Jersey corporation
WellCare Health Plans of Rhode Island, Inc., a Rhode Island corporation
WellCare Health Plans of Vermont, Inc., a Vermont corporation
WellCare Health Plans, Inc., a Delaware corporation
WellCare National Health Insurance Company, a Texas corporation
WellCare of Alabama, Inc., an Alabama corporation
WellCare of California, Inc., a California corporation
WellCare of Connecticut, Inc., a Connecticut corporation
WellCare of Georgia, Inc., a Georgia corporation
WellCare of Illinois, Inc., an Illinois corporation
WellCare of Indiana, Inc., an Indiana corporation
WellCare of Maine, Inc., a Maine corporation
WellCare of Michigan Holding Company, a Michigan corporation
WellCare of Mississippi, Inc., a Mississippi corporation
WellCare of Missouri Health Insurance Company, Inc., a Missouri corporation
WellCare of New Hampshire, Inc., a New Hampshire corporation
WellCare of North Carolina, Inc., a North Carolina corporation
WellCare of Oklahoma, Inc., an Oklahoma corporation
WellCare of Pennsylvania, Inc., a Pennsylvania corporation
WellCare of South Carolina, Inc., a South Carolina corporation
WellCare of Texas, Inc., a Texas corporation
WellCare of Virginia, Inc., a Virginia corporation
WellCare of Washington, Inc., a Washington corporation
WellCare Prescription Insurance, Inc., an Arizona corporation
Western Sky Community Care, Inc., a New Mexico corporation
Worlco Management Services, Inc., a New York corporation

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the registration statements Nos. 333-261993, 333-255735, 333-238597, 333-236036, 333-217634, 333-210376, 333-197737, 333-180976, and 333-90976 on Form S-8 of our reports dated February 20, 2024, with respect to the consolidated financial statements of Centene Corporation and the effectiveness of internal control over financial reporting.

/s/ KPMG LLP

St. Louis, Missouri
February 20, 2024

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 20, 2024

/s/ SARAH M. LONDON

Chief Executive Officer
(principal executive officer)

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 20, 2024

/s/ ANDREW L. ASHER

Executive Vice President, Chief Financial Officer
(principal financial officer)

**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, 2023, 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 20, 2024

/s/ SARAH M. LONDON

Chief Executive Officer
(principal executive officer)

**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, 2023, 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 20, 2024

/s/ ANDREW L. ASHER

Executive Vice President, Chief Financial Officer
(principal financial officer)

CENTENE CORPORATION**CLAWBACK POLICY**

The Compensation and Talent Committee (the “Committee”) of the Board of Directors (the “Board”) of Centene Corporation (the “Company”) believes that it is appropriate for the Company to adopt this Clawback Policy (the “Policy”) to be applied to the Executive Officers of the Company and adopts this Policy to be effective as of the Effective Date.

1. Definitions

For purposes of this Policy, the following definitions shall apply:

- a) “Company Group” means the Company and each of its Subsidiaries, as applicable.
- b) “Covered Compensation” means any Incentive-Based Compensation granted, vested or paid to a person who served as an Executive Officer at any time during the performance period for the Incentive-Based Compensation and that was Received (i) on or after the effective date of the NYSE listing standard, (ii) after the person became an Executive Officer and (iii) at a time that the Company had a class of securities listed on a national securities exchange or a national securities association.
- c) “Effective Date” means October 2, 2023.
- d) “Erroneously Awarded Compensation” means the amount of Covered Compensation granted, vested or paid to a person during the fiscal period when the applicable Financial Reporting Measure relating to such Covered Compensation was attained that exceeds the amount of Covered Compensation that otherwise would have been granted, vested or paid to the person had such amount been determined based on the applicable Restatement, computed without regard to any taxes paid (i.e., on a pre-tax basis). For Covered Compensation based on stock price or total shareholder return, where the amount of Erroneously Awarded Compensation is not subject to mathematical recalculation directly from the information in a Restatement, the Committee will determine the amount of such Covered Compensation that constitutes Erroneously Awarded Compensation, if any, based on a reasonable estimate of the effect of the Restatement on the stock price or total shareholder return upon which the Covered Compensation was granted, vested or paid and the Committee shall maintain documentation of such determination and provide such documentation to the NYSE.
- e) “Exchange Act” means the Securities Exchange Act of 1934.
- f) “Executive Officer” means each “officer” of the Company as defined under Rule 16a-1(f) under Section 16 of the Exchange Act, which shall be deemed to include any individuals identified by the Company as executive officers pursuant to Item 401(b) of Regulation S-K under the Exchange Act. Both current and former Executive Officers are subject to the Policy in accordance with its terms.

- g) “Financial Reporting Measure” means (i) any measure that is determined and presented in accordance with the accounting principles used in preparing the Company’s financial statements, and any measures derived wholly or in part from such measures and may consist of GAAP or non-GAAP financial measures (as defined under Regulation G of the Exchange Act and Item 10 of Regulation S-K under the Exchange Act), (ii) stock price or (iii) total shareholder return. Financial Reporting Measures may or may not be filed with the SEC and may be presented outside the Company’s financial statements, such as in Managements’ Discussion and Analysis of Financial Conditions and Result of Operations or in the performance graph required under Item 201(e) of Regulation S-K under the Exchange Act.
- h) “Home Country” means the Company’s jurisdiction of incorporation.
- i) “Incentive-Based Compensation” means any compensation that is granted, earned or vested based wholly or in part upon the attainment of a Financial Reporting Measure.
- j) “Lookback Period” means the three completed fiscal years (plus any transition period of less than nine months that is within or immediately following the three completed fiscal years and that results from a change in the Company’s fiscal year) immediately preceding the date on which the Company is required to prepare a Restatement for a given reporting period, with such date being the earlier of: (i) the date the Board, a committee of the Board, or the officer or officers of the Company authorized to take such action if Board action is not required, concludes, or reasonably should have concluded, that the Company is required to prepare a Restatement, or (ii) the date a court, regulator or other legally authorized body directs the Company to prepare a Restatement. Recovery of any Erroneously Awarded Compensation under the Policy is not dependent on if or when the Restatement is actually filed.
- k) “NYSE” means the New York Stock Exchange.
- l) “Received”: Incentive-Based Compensation is deemed “Received” in the Company’s fiscal period during which the Financial Reporting Measure specified in or otherwise relating to the Incentive-Based Compensation award is attained, even if the grant, vesting or payment of the Incentive-Based Compensation occurs after the end of that period.
- m) “Restatement” means a required accounting restatement of any Company financial statement due to the material noncompliance of the Company with any financial reporting requirement under the securities laws, including (i) to correct an error in previously issued financial statements that is material to the previously issued financial statements (commonly referred to as a “Big R” restatement) or (ii) to correct an error in previously issued financial statements that is not material to the previously issued financial statements but that would result in a material misstatement if the error were corrected in the current period or left uncorrected in the current period (commonly referred to as a “little r” restatement). Changes to the Company’s financial statements that do not represent error corrections under the then-current relevant accounting standards will not constitute Restatements. Recovery of any Erroneously Awarded Compensation under the Policy is not dependent on fraud or misconduct by any person in connection with the Restatement.
- n) “SEC” means the United States Securities and Exchange Commission.

- o) “Subsidiary” means any domestic or foreign corporation, partnership, association, joint stock company, joint venture, trust or unincorporated organization “affiliated” with the Company, that is, directly or indirectly, through one or more intermediaries, “controlling”, “controlled by” or “under common control with”, the Company. “Control” for this purpose means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of such person, whether through the ownership of voting securities, contract or otherwise.

2. Recoupment of Erroneously Awarded Compensation

In the event of a Restatement, any Erroneously Awarded Compensation Received during the Lookback Period prior to the 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 any person shall be subject to reasonably prompt repayment to the Company Group in accordance with Section 3 of this Policy. The Committee must pursue (and shall not have the discretion to waive) the forfeiture and/or repayment of such Erroneously Awarded Compensation in accordance with Section 3 of this Policy, except as provided below.

Notwithstanding the foregoing, the Committee (or, if the Committee is not a committee of the Board responsible for the Company’s executive compensation decisions and composed entirely of independent directors, a majority of the independent directors serving on the Board) may determine not to pursue the forfeiture and/or recovery of Erroneously Awarded Compensation from any person if the Committee determines that such forfeiture and/or recovery would be impracticable due to any of the following circumstances: (i) the direct expense paid to a third party (for example, reasonable legal expenses and consulting fees) to assist in enforcing the Policy would exceed the amount to be recovered (following reasonable attempts by the Company Group to recover such Erroneously Awarded Compensation, the documentation of such attempts, and the provision of such documentation to the NYSE), (ii) pursuing such recovery would violate the Company’s Home Country laws adopted prior to November 28, 2022 (provided that the Company obtains an opinion of Home Country counsel acceptable to the NYSE that recovery would result in such a violation and provides such opinion to the NYSE), or (iii) recovery would likely cause any otherwise tax-qualified retirement plan, under which benefits are broadly available to employees of Company Group, to fail to meet the requirements of 26 U.S.C. 401(a)(13) or 26 U.S.C. 411(a) and regulations thereunder.

3. Means of Repayment

In the event that the Committee determines that any person shall repay any Erroneously Awarded Compensation, the Committee shall provide written notice to such person by email or certified mail to the physical address on file with the Company Group for such person, and the person shall satisfy such repayment in a manner and on such terms as required by the Committee, and the Company Group shall be entitled to set off the repayment amount against any amount owed to the person by the Company Group, to require the forfeiture of any award granted by the Company Group to the person, or to take any and all necessary actions to reasonably promptly recoup the repayment amount from the person, in each case, to the fullest extent permitted under applicable law, including without limitation, Section 409A of the Internal Revenue Code and the regulations and guidance thereunder. If the Committee does not specify a repayment timing in the written notice described above, the applicable person shall be required to repay the Erroneously Awarded Compensation to the Company Group by wire, cash or cashier’s check no later than thirty (30) days after receipt of such notice.

4. No Indemnification

No person shall be indemnified, insured or reimbursed by the Company Group in respect of any loss of compensation by such person in accordance with this Policy, nor shall any person receive any advancement of expenses for disputes related to any loss of compensation by such person in accordance with this Policy, and no person shall be paid or reimbursed by the Company Group for any premiums paid by such person for any third-party insurance policy covering potential recovery obligations under this Policy. For this purpose, “indemnification” includes any modification to current compensation arrangements or other means that would amount to *de facto* indemnification (for example, providing the person a new cash award which would be cancelled to effect the recovery of any Erroneously Awarded Compensation). In no event shall the Company Group be required to award any person an additional payment if any Restatement would result in a higher incentive compensation payment.

5. Miscellaneous

This Policy generally will be administered and interpreted by the Committee, provided that the Board may, from time to time, exercise discretion to administer and interpret this Policy, in which case, all references herein to “Committee” shall be deemed to refer to the Board. Any determination by the Committee with respect to this Policy shall be final, conclusive and binding on all interested parties. Any discretionary determinations of the Committee under this Policy, if any, need not be uniform with respect to all persons, and may be made selectively amongst persons, whether or not such persons are similarly situated.

This Policy is intended to satisfy the requirements of Section 954 of the Dodd-Frank Wall Street Reform and Consumer Protection Act, as it may be amended from time to time, and any related rules or regulations promulgated by the SEC or the NYSE, including any additional or new requirements that become effective after the Effective Date which upon effectiveness shall be deemed to automatically amend this Policy to the extent necessary to comply with such additional or new requirements.

The provisions in this Policy are intended to be applied to the fullest extent of the law. To the extent that any provision of this Policy is found to be unenforceable or invalid under any applicable law, such provision will be applied to the maximum extent permitted and shall automatically be deemed amended in a manner consistent with its objectives to the extent necessary to conform to applicable law. The invalidity or unenforceability of any provision of this Policy shall not affect the validity or enforceability of any other provision of this Policy. Recoupment of Erroneously Awarded Compensation under this Policy is not dependent upon the Company Group satisfying any conditions in this Policy, including any requirements to provide applicable documentation to the NYSE.

The rights of the Company Group under this Policy to seek forfeiture or reimbursement are in addition to, and not in lieu of, any rights of recoupment, or remedies or rights other than recoupment, that may be available to the Company Group pursuant to the terms of any law, government regulation or stock exchange listing requirement or any other policy, code of conduct, employee handbook, employment agreement, equity award agreement, or other plan or agreement of the Company Group.

6. Amendment and Termination

To the extent permitted by, and in a manner consistent with applicable law, including SEC and NYSE rules, the Committee may terminate, suspend or amend this Policy at any time in its discretion.

7. Successors

This Policy shall be binding and enforceable against all persons and their respective beneficiaries, heirs, executors, administrators or other legal representatives with respect to any Covered Compensation granted, vested or paid to or administered by such persons or entities.

Approved by the Compensation and Talent Committee of the Board of Directors on September 26, 2023.

CENTENE CORPORATION

CLAWBACK POLICY

ACKNOWLEDGMENT, CONSENT AND AGREEMENT

I acknowledge that I have received and reviewed a copy of the Centene Corporation Clawback Policy (as may be amended from time to time, the "Policy") and I have been given an opportunity to ask questions about the Policy and review it with my counsel. I knowingly, voluntarily and irrevocably consent to and agree to be bound by and subject to the Policy's terms and conditions, including that I will return any Erroneously Awarded Compensation that is required to be repaid in accordance with the Policy. I further acknowledge, understand and agree that (i) the compensation that I receive, have received or may become entitled to receive from the Company Group is subject to the Policy, and the Policy may affect such compensation and (ii) I have no right to indemnification, insurance payments or other reimbursement by or from the Company Group for any compensation that is subject to recoupment and/or forfeiture under the Policy. Capitalized terms not defined herein have the meanings set forth in the Policy.

Signed: _____

Printed Name: _____

Date: _____