OXFORD INDUSTRIES INC
Form DEF 14A
September 09, 2005

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549
SCHEDULE 14A
(RULE 14a-101)
INFORMATION REQUIRED IN PROXY STATEMENT
SCHEDULE 14A INFORMATION
Proxy Statement Pursuant to Section 14(a) of the Securities Exchange Act of 1934

Filed by the Registrant x

Filed by a Party other than the Registrant o
Check the appropriate box:

- o Preliminary Proxy Statement
- o Confidential, for Use of the Commission Only (as permitted by Rule 14a-6(e)(2))
- x Definitive Proxy Statement
- o Definitive Additional Materials
- o Soliciting Material Pursuant to Section 240.14a-12

OXFORD INDUSTRIES, INC.
(Name of Registrant as Specified In Its Charter)
N/A
(Name of Person(s) Filing Proxy Statement, if other than the Registrant)

Payment of Filing Fee (Check the appropriate box):

- x No fee required.

- o Fee computed on table below per Exchange Act Rules 14a-6(i)(1) and 0-11.
  - (1) Title of each class of securities to which transaction applies:
  - (2) Aggregate number of securities to which transaction applies:
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  - (4) Proposed maximum aggregate value of transaction:
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- o Fee paid previously with preliminary materials:

- o Check box if any part of the fee is offset as provided by Exchange Act Rule 0-11(a)(2) and identify the filing for which the offsetting fee was paid previously. Identify the previous filing by registration statement number, or the Form or Schedule and the date of its filing.
  - (1) Amount previously paid:
  - (2) Form, Schedule or Registration Statement No.:

(3) Filing Party:

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NOTICE AND PROXY STATEMENT

OXFORD INDUSTRIES, INC.
222 Piedmont Avenue, N.E.
Atlanta, Georgia 30308

NOTICE OF ANNUAL MEETING OF SHAREHOLDERS
To Be Held on October 10, 2005

TIME:	3:00 p.m., local time on Monday, October 10, 2005
PLACE:	Oxford Industries, Inc. 222 Piedmont Avenue, N.E. Atlanta, Georgia 30308
ITEMS OF BUSINESS:	(1) To elect three directors; (2) To ratify the appointment of Ernst & Young LLP, independent registered public accounting firm, as the Company s independent auditors for the fiscal year ending June 2, 2006; and (3) To transact any other business that properly comes before the meeting or any adjournment of the annual meeting.
WHO MAY VOTE:	You may vote if you were a holder of record of Common Stock on August 22, 2005.
DATE OF NOTICE:	September 6, 2005
DATE OF MAILING:	This notice and the proxy statement are first being mailed to shareholders on or about September 6, 2005.

EVEN IF YOU PLAN TO ATTEND THE MEETING, PLEASE COMPLETE AND SIGN THE ENCLOSED PROXY AND RETURN IT IN THE ACCOMPANYING POSTAGE-PREPAID ENVELOPE. YOU MAY REVOKE YOUR PROXY AT ANY TIME BEFORE THE MEETING AND, IF YOU ATTEND THE MEETING, YOU MAY ELECT TO VOTE IN PERSON.

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OXFORD INDUSTRIES, INC.
222 Piedmont Avenue, N.E.
Atlanta, Georgia 30308

PROXY STATEMENT

For Annual Meeting of Shareholders
To Be Held on October 10, 2005
ABOUT THE MEETING

What is a proxy?

It is your legal designation of another person to vote the stock you own. That other person is called a proxy. If you designate someone as your proxy in a written document, that document also is called a proxy or a proxy card. We have designated three of our officers as proxies for our 2005 Annual Meeting of Shareholders. These three officers are J. Hicks Lanier, Thomas Caldecot Chubb III and Sheridan B. Johnson.

Who is furnishing this proxy statement?

This proxy statement is being furnished to our shareholders by our Board of Directors in connection with the solicitation of proxies by the Board. The proxies will be used at our annual meeting of shareholders to be held on October 10, 2005. This proxy statement and the accompanying proxy will be first mailed to shareholders on or about September 6, 2005.

What am I voting on?

You will be voting on each of the following:

1. To elect three directors;

2. To ratify the appointment of Ernst & Young LLP, independent registered public accounting firm, as the Company s independent auditors for the fiscal year ending June 2, 2006; and

3. To transact any other business that properly comes before the meeting or any adjournment of the annual meeting.

As of the date of this proxy statement, the Board of Directors knows of no other matter that will be brought before the annual meeting.

You may not cumulate your votes for any matter being voted on at the annual meeting, and you are not entitled to appraisal or dissenter s rights.

Who may vote?

You may vote if you own shares of our Common Stock as of the close of business on August 22, 2005, the record date for the annual meeting of shareholders. As of August 22, 2005, there were 17,043,862 shares of our Common Stock outstanding.

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How do I vote?

You may vote using one of the following methods:

By completing, signing and returning the enclosed proxy; or

By attending the annual meeting and voting in person.

If you hold your shares in the name of a bank or broker, the availability of telephone and Internet voting depends on their voting processes. Please follow the directions on your proxy card carefully.

May I vote at the annual meeting?

You may vote your shares at the annual meeting if you attend in person. Even if you plan to be present at the annual meeting, we encourage you to vote your shares by proxy. You may vote your proxy by mail.

What if my shares are registered in more than one person s name?

If you own shares that are registered in the name of more than one person, each person must sign the enclosed proxy. If the proxy is signed by an attorney, executor, administrator, trustee, guardian or by any other person in a representative capacity, the full title of the person signing the proxy should be given and a certificate should be furnished showing evidence of appointment.

What does it mean if I receive more than one proxy?

It means you have multiple accounts with brokers and/or our transfer agent. Please vote all of these shares. We recommend that you contact your broker and/or our transfer agent to consolidate as many accounts as possible under the same name and address. Our transfer agent is SunTrust Bank, Atlanta, Mail Code 258, P.O. Box 4625, Atlanta, Georgia 30302, and may be reached at 1-800-568-3476.

What if I return my proxy but do not provide voting instructions?

If you sign and return your proxy but do not include voting instructions, your proxy will be voted:

FOR the election of the nominee directors named in this proxy statement;

FOR the ratification of the appointment of Ernst & Young LLP, independent registered public accounting firm, as the Company s independent auditors for the fiscal year ending June 2, 2006.

A properly executed card marked Abstain with respect to any proposal will not be voted.

May I change my mind after I vote?

You may change your vote at any time before the polls close at the annual meeting. You may do this by using one of the following methods:

Giving written notice to the Secretary of our Company.

Delivering a later-dated proxy.

Voting in person at the annual meeting.

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How many votes am I entitled to?

You are entitled to one vote for each share of our Common Stock that you own.

How many votes must be present to hold the annual meeting?

In order for us to conduct the annual meeting, the holders of a majority of the votes of the Common Stock outstanding as of August 22, 2005 must be present at the annual meeting. This is referred to as a quorum. Your shares will be counted as present at the annual meeting if you do one of the following:

Return a properly executed proxy (even if you do not provide voting instructions); or

Attend the annual meeting and vote in person.

How many votes are needed to elect directors?

To elect the Class I directors, the FOR votes cast at the annual meeting must exceed the AGAINST votes cast at the annual meeting. If you do not vote in person or sign and return a proxy, your shares will not be counted as FOR votes or AGAINST votes at the annual meeting.

How many votes are needed to ratify the appointment of Ernst & Young LLP, independent registered public accounting firm, as the Company s independent auditors for the fiscal year ending June 2, 2006?

To ratify the appointment of Ernst & Young LLP, independent registered public accounting firm, as the Company s independent auditors for the fiscal year ending June 2, 2006, the FOR votes cast at the annual meeting must exceed the AGAINST votes cast at the annual meeting. If you do not vote in person or sign and return a proxy, your shares will not be counted as FOR votes or AGAINST votes at the annual meeting.

How many votes are needed for other matters?

To approve any other matter that properly comes before the annual meeting, the FOR votes cast in favor of the matter must exceed the AGAINST votes cast against the matter. The Board knows of no other matters that will be brought before the annual meeting. If other matters are properly introduced, the persons named in the enclosed proxy as the proxy holders will vote on such matters in their discretion.

Will my shares be voted if I do not provide my proxy?

Your shares may be voted under certain circumstances if they are held in the name of a brokerage firm. Brokerage firms have the authority under rules of the New York Stock Exchange (which we refer to as the NYSE) to vote customers unvoted shares on routine matters, which includes the election of directors and the ratification of the appointment of independent auditors. Accordingly, if a brokerage firm votes your shares on these matters in accordance with these rules, your shares will count as present at the annual meeting for purposes of establishing a quorum and will count as FOR votes or AGAINST votes, as the case may be, with respect to all routine matters voted on at the annual meeting. If you hold your shares directly in your own name, they will not be voted if you do not provide a proxy. When a proposal is not a routine matter and the brokerage firm has not received voting instructions from the beneficial owner of the shares with respect to that proposal, the brokerage firm cannot vote the shares on that proposal. If a brokerage firm signs and returns a proxy on your behalf that does not contain voting instructions, your shares will count as present

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at the annual meeting for quorum purposes, but will not count as FOR votes or AGAINST votes on any matter voted on at the annual meeting. These are referred to as broker non-votes.

ELECTION OF DIRECTORS
(Item 1)

Board of Directors

Our Board of Directors currently has eleven members. However, the Board recently amended our Bylaws to reduce the number of members of the Board to ten effective October 10, 2005. This change will reflect the retirement of Mr. Knowlton J. O Reilly from the Board on that date. Mr. O Reilly is retiring from the Board because he has attained age 65, which is the retirement age for most employee directors (see the table below). Mr. O Reilly will continue to serve as Group Vice President of the Company following his retirement from the Board.

The directors are divided into three classes that are as nearly equal in size as possible. To maintain a nearly-equal class size following Mr. O Reilly s retirement from the Board, the Board nominated Mr. Robert E. Shaw for election as a Class I director at the 2005 Annual Meeting of Shareholders, removing him from the group of Class II directors whose terms will expire at the 2006 Annual Meeting of Shareholders. Directors in each class are elected to staggered three-year terms. A director holds office until the annual meeting of shareholders held in the year during which the director s term ends or until a successor is elected and qualified.

The Board has nominated Cecil D. Conlee, J. Reese Lanier, Sr. and Robert E. Shaw for election as Class I directors to hold office until 2008. If a nominee becomes unable to serve as a director, a proxy may, in the discretion of the person(s) named in the proxy, be voted for a substitute nominee or may not be voted at all. Each nominee has consented to serve if elected, and the Board of Directors has no reason to believe that any nominee will be unable to serve.

Directors must retire when they reach the applicable age set forth in the table below. However, a director may continue to serve until the end of the term of service during which he or she attains retirement age.

Type of Director	Age
Employee directors (other than our Chief Executive Officer)	65
Our Chief Executive Officer (if she or he is a director)	72
Non-employee directors not actively employed by a company in which such director does not beneficially own a controlling interest	72
Non-employee directors actively employed by a company in which such director does not beneficially own a controlling interest	75

Our Board may amend our Bylaws to change the size of the board and may fill any vacancies created by an increase in the size of the Board.

We do not believe that any of the nominees for director will be unwilling or unable to serve as director. However, if at the time of the annual meeting any of the nominees should be unwilling or unable to serve, proxies will be voted as recommended by the Board to do one of the following:

to elect substitute nominees recommended by the Board;

to allow the vacancy created to remain open until filled by the Board; or

to reduce the number of directors for the ensuing year.

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Recommendation of the Board of Directors

THE BOARD OF DIRECTORS RECOMMENDS A VOTE FOR THIS PROPOSAL.

Nominees for Election Class I Directors Terms Expire in 2008

Name	Age	Director Since	Positions Held
J. Reese Lanier, Sr.*	62	1974	Mr. Lanier is self-employed in farming and related businesses and has had this occupation for more than five years.
Cecil D. Conlee	69	1985	Mr. Conlee is Chairman of CGR Advisors, a real estate advisory company, and has held this position since 1990. He is also a director of Central Parking Corporation. Mr. Conlee serves on the Audit Committees of Central Parking Corporation and Vanderbilt University. He is Chairman of the Compensation Committee of Central Parking Corporation.
Robert E. Shaw	74	1991	Mr. Shaw is Chairman of the Board and Chief Executive Officer of Shaw Industries, Inc., a manufacturer and seller of carpeting to retailers and distributors, and has held those positions since 1995 and 1990, respectively.

Continuing Class II Directors Terms Expire in 2006

Name	Age	Director Since	Positions Held
J. Hicks Lanier*	65	1969	Mr. Lanier has been Chairman and Chief Executive Officer of the Company since 1981. Mr. Lanier also served as President of the Company from 1977 until 2003. He serves as a director of SunTrust Banks, Inc., Crawford & Company and Genuine Parts Company. He serves on the Audit Committee of SunTrust Bank and Crawford & Company. He also serves on the Compensation Committee of Genuine Parts Company and Crawford & Company.
Thomas C. Gallagher	57	1991	Mr. Gallagher is Chairman, Chief Executive Officer and President of Genuine Parts Company, a distributor of automotive replacement parts, industrial products, office supplies and electrical and electronic parts. He was appointed Chief Executive Officer in 2004 and President in 1990. He is also a director of STI Classic Funds and STI Classic Variable Trust. He is a member of the Audit Committee of STI Classic Funds.
Clarence H. Smith	54	2003	Mr. Smith is President and Chief Executive Officer of Haverty Furniture Companies, Inc., a home

furnishings retailer, and has held this position since January 2003. He served as President and Chief Operating Officer of Haverty Furniture Companies, Inc. from 2002 to 2003, Chief Operating Officer from 2000 to 2002, and Senior Vice President, General Manager Stores from 1996 to 2000. He is also a director of Haverty Furniture Companies, Inc.

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Continuing Class III Directors Terms Expire in 2007

Name	Age	Director Since	Positions Held
E. Jenner Wood III	54	1995	Mr. Wood became Chairman, President and Chief Executive Officer of Sun Trust Bank, Central Group, in March 2001. Mr. Wood served as Executive Vice President of SunTrust Banks, Inc. from 1994 until 2001. SunTrust Banks, Inc. is a financial holding company that through its flagship subsidiary, SunTrust Bank, offers deposit, credit and trust and investment services. Mr. Wood is a director of Crawford & Company and serves on its Compensation Committee. He is also a director of Georgia Power Company and serves on its Audit Committee.
Helen B. Weeks	51	1998	Ms. Weeks founded Ballard Designs, Inc., a home furnishing catalog business, in 1983 and served as Chief Executive Officer until she retired in 2002.
S. Anthony Margolis	63	2003	Mr. Margolis has been a Group Vice President of the Company and Chief Executive Officer of Tommy Bahama Group, Inc. (formerly known as Viewpoint International, Inc.) since 2003. Prior to joining the Company, Mr. Margolis had been the Chief Executive Officer and President of Viewpoint International, Inc. since 1992.
James A. Rubright	58	2004	Mr. Rubright has served as Chief Executive Officer of Rock-Tenn Company, a manufacturer of paperboard, paperboard packaging and merchandising displays for sale primarily to non-durable goods producers, since October 1999 and Chairman of its Board of Directors since January 2000. Mr. Rubright is a director of AGL Resources Inc., an energy company, and serves on its Compensation Committee. He is also a director of Avondale Incorporated, a textile manufacturing company, and serves on its Audit Committee.

* J. Hicks Lanier and J. Reese Lanier, Sr. are first cousins. J. Reese Lanier, Jr., an executive officer of the Company, is the son of J. Reese Lanier, Sr.

Corporate Governance

Director Independence. The Board has determined that the following directors are independent: Cecil D. Conlee, James A. Rubright, Robert E. Shaw, Clarence H. Smith, Helen B. Weeks and E. Jenner Wood III. In determining director independence, the Board broadly considers all relevant facts and circumstances when making a determination of independence, including the corporate governance listing standards of the NYSE. The Board considers the issue not merely from the standpoint of a director, but also from that of persons or organizations with which the director has an

affiliation. An independent director is free of any relationship with our Company or our management that impairs the director s ability to make independent judgments. The Board has determined that each of these directors has no material relationship with our Company (either directly or as a partner, shareholder or officer of an organization that has a relationship with our Company). Mr. E. Jenner Wood III has certain relationships with our Company that are described elsewhere in this proxy statement under the heading *Certain Transactions.* The Board has

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determined that this relationship is not material for purposes of determining Mr. Wood s independence in accordance with the NYSE corporate governance listing standards.

Corporate Governance Guidelines. We have posted our Corporate Governance Guidelines on our Internet website at *www.oxfordinc.com.*

Director Self-Evaluation. Our Corporate Governance Guidelines provide that our Board will conduct an annual self-evaluation of the Board and its Committees. The Corporate Governance Guidelines provide that the Nominating, Compensation and Governance Committee is responsible for overseeing the self-evaluation process.

Meetings of Non-Employee Directors. Pursuant to our Corporate Governance Guidelines, our non-employee directors periodically meet separately from the other directors. Our non-employee directors include directors who are independent, as defined in the NYSE corporate governance listing standards, and any other directors who are not officers of our Company even though they may have another relationship to our Company or our management that prevents them from being considered independent under the NYSE standards.

Presiding Independent Director. Robert E. Shaw is the presiding independent director, in accordance with our Corporate Governance Guidelines.

Submission of Candidates by Shareholders. Shareholders may recommend candidates for consideration by the Nominating, Compensation and Governance Committee by submitting a written recommendation to the Secretary of the Company. The recommendation must be sent by certified or registered mail and received by the time specified in the Company s Proxy Statement as the deadline for submitting shareholder proposals for consideration at the Company s Annual Meeting. In addition to the information required below, the shareholder must provide his or her own name, number of shares owned and the date the shares were purchased. Any recommendation received by the Secretary will be promptly forwarded to the Chairman of the Nominating, Compensation and Governance Committee.

Regardless of the source of the recommendation, the Nominating, Compensation and Governance Committee must be provided the following information for new candidates being recommended:

(1) the name, age, business address and residence address of the candidate;

(2) the candidate s resume, which must describe, among other things, the candidate s principal occupation or employment history, other directorships held, material outside commitments and the names of all other business entities of which the candidate owns a 10% beneficial interest;

(3) a statement from the candidate describing the reasons for seeking election to the Board of Directors;

(4) the number of shares of the Company s stock that are beneficially owned by the candidate;

(5) the candidate s consent to stand for election if nominated by the Board and to serve if elected by the shareowners; and

(6) any other information that may assist the Committee in evaluating the candidate or that the Committee may request.

In addition to candidates submitted by shareholders, the Committee will also consider candidates recommended by directors, management, third party search firms, or any other valid or reliable source.

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The Committee strives to identify and recruit the best-qualified candidates that are available. The Committee will compile a complete list of candidates recommended from any valid source and evaluate each candidate. Each candidate will be evaluated in the context of the current composition of the Board, the current needs of the Board and the long-term interests of the shareholders. After evaluating each candidate, the Committee will vote on which candidates will be recommended to the full Board.

Meetings of the Board of Directors

The Board met seven times during our fiscal year that ended on June 3, 2005 (fiscal 2005). Each of the directors other than Robert E. Shaw attended at least 75% of all meetings of the Board and Committees on which they served in fiscal 2005. While the Company has not adopted a formal policy regarding attendance by members of the Board at the Annual Meeting of Shareholders, each of the directors attended the Company s 2004 Annual Meeting of Shareholders.

Committees of the Board of Directors

The Board has an Executive Committee, an Audit Committee and a Nominating, Compensation and Governance Committee.

Executive Committee. Messrs. J. Hicks Lanier, Knowlton J. O Reilly and Robert E. Shaw are the members of the Executive Committee. Mr. J. Hicks Lanier is chairman of the Committee.

The Executive Committee is authorized to exercise the authority of the full board in managing the business and affairs of our Company. However, the Executive Committee does not have certain powers, including the following:

(1) to fill vacancies on the Board;

(2) to adopt, amend or repeal our Bylaws; or

(3) to approve or propose to shareholders action that Georgia law requires to be approved by shareholders.

The Executive Committee met once in fiscal 2005.

Audit Committee. Cecil D. Conlee, James A. Rubright and Clarence H. Smith are the members of the Audit Committee. Mr. Conlee is chairman of the Committee. We have posted the Committee s charter on our Internet website at *www.oxfordinc.com.* The Board has determined that Mr. Conlee is an Audit Committee financial expert as that term is defined in Item 401(h)(1) of Regulation S-K under the Securities Act of 1933, as amended (which we refer to as the Securities Act), and the Securities Exchange Act of 1934, as amended (which we refer to as the Exchange Act). The Board has also determined that all members of the Committee are independent and are financially literate. See *Board of Directors Corporate Governance Director Independence* above.

The Board established the Audit Committee (in accordance with Rule 10A-3 of the Exchange Act) to assist the Board in fulfilling its responsibilities with respect to the oversight of the following:

(1) the integrity of our financial statements, reporting processes and systems of internal controls;

(2) our compliance with applicable laws and regulations;

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(3) the qualifications and independence of our independent auditors; and

(4) the performance of our internal audit department and our independent auditors.

The principal duties and responsibilities of the Audit Committee are set forth in its charter. The Audit Committee may exercise additional authority prescribed from time to time by the Board.

The Audit Committee met five times in fiscal 2005, including meetings to review each of the quarterly earnings releases.

Nominating, Compensation and Governance Committee. Cecil D. Conlee, Robert E. Shaw and Helen B. Weeks are the members of the Nominating, Compensation and Governance Committee. Mr. Shaw is chairman of the Committee. We have posted the Committee s charter on our Internet website at *www.oxfordinc.com.* The Board has determined that all members of the Committee are independent. See *Board of Directors Corporate Governance Director Independence* above.

The purpose of the Nominating, Compensation and Governance Committee is to:

(1) assist our Board in fulfilling its responsibilities with respect to compensation of our executive officers;

(2) establish criteria for the selection of new directors to serve on the Board;

(3) recommend candidates for all directorships to be filled;

(4) identify individuals qualified to serve as members of our Board;

(5) review and recommend Committee appointments;

(6) consider questions of independence and possible conflicts of interest of members of the Board and our executive officers;

(7) take a leadership role in shaping our corporate governance;

(8) develop and recommend to the Board for adoption our Corporate Governance Guidelines;

(9) lead the Board in the Board s annual review of its own performance; and

(10) perform other functions that it deems necessary or appropriate.

The Nominating, Compensation and Governance Committee also has the following responsibilities related to determining the compensation of executive officers:

(1) administer our stock option and restricted stock plans;

(2) administer our Executive Performance Incentive Plan;

(3) review and approve corporate goals and objectives relevant to the compensation of our Chief Executive Officer (CEO);

(4) evaluate the CEO s performance in light of those goals and objectives;

(5) determine the compensation of the CEO based upon this evaluation;

(6) review and approve the compensation of our executive officers;

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(7) make recommendations to the Board regarding non-chief executive officer compensation, incentive-compensation plans and equity-based plans; and

(8) annually prepare a report on Executive Compensation for inclusion in our proxy statement.

In determining the long-term incentive component of the CEO s compensation, the Committee considers our performance and relative shareholder return, the value of similar incentive awards to CEOs at comparable companies, the awards given to the CEO in past years and such other factors as the Committee deems relevant.

The Nominating, Compensation and Governance Committee met twice during fiscal 2005.

Compensation of Directors

For fiscal 2005, a non-employee director who served as Chairman of the Audit Committee or the Nominating, Compensation and Governance Committee received an annual retainer of $30,000. All other non-employee directors received an annual retainer of $24,000. Each non-employee director is required to receive at least one-half of his or her annual retainer in the form of restricted stock of the Company and may elect to receive the remainder of the annual retainer in cash or in restricted stock of the Company. Each non-employee director receives a $1,250 meeting fee for each Board and Committee meeting attended. Directors are reimbursed for their out-of-pocket expenses in attending meetings. Directors who are employees of the Company do not receive an annual retainer or meeting fees.

COMMON STOCK OWNERSHIP BY MANAGEMENT AND CERTAIN BENEFICIAL OWNERS

The table below sets forth certain information, as of August 22, 2005 (except as noted), regarding the beneficial ownership of shares of our Common Stock by:

owners of 5% or more of our Common Stock;

our directors;

our named executive officers, as defined in *Executive Compensation Summary Compensation Table* ; and

our directors and executive officers as a group.

Except as set forth below, the shareholders named below have sole voting and investment power with respect to all shares of our Common Stock shown as being beneficially owned by them. Under the rules of the Securities and Exchange Commission (the SEC), a person beneficially owns securities which that person has the right to purchase within 60 days. Under these rules, more than one person may be deemed to beneficially own the same securities, and a person may be deemed to beneficially own securities in which he or

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she has no financial interest. Unless otherwise indicated, the address for each shareholder on this table is c/o Oxford Industries, Inc., 222 Piedmont Avenue, N.E., Atlanta, Georgia 30308.

	Beneficial Ownership of Common Stock	
Name	**Number of Shares**	**Percent of Class(1)**
Apex Capital, LLC	1,264,000(a)	7.35%
Buckingham Capital Management Incorporated	1,104,200(b)	6.42%
Columbia Wanger Asset Management, L.P.	1,675,800(c)	9.75%
SunTrust Banks, Inc.	947,728(d)	5.51%
Systematic Financial Management, L.P.	910,227(e)	5.29%
Thomas C. Chubb III	25,903(f)	*
Cecil D. Conlee	7,224	*
Thomas C. Gallagher	4,289	*
J. Hicks Lanier	1,673,799(g)	9.74%
J. Reese Lanier, Sr.	600,160(h)	3.49%
S. Anthony Margolis	36,555(i)	*
Knowlton J. O Reilly	23,312(j)	*
James A. Rubright	434	*
Michael J. Setola	12,500(k)	*
Robert E. Shaw	2,724	*
Clarence H. Smith	689	*
Helen B. Weeks	289	*
E. Jenner Wood III	1,289	*
All directors and executive officers as a group (18 persons)	2,450,300(l)	14.26%

* Less than 1%

(1) Based on an aggregate of 17,187,132 shares of our Common Stock, which represents 17,043,862 shares of our Common Stock issued and outstanding as of August 22, 2005 *plus* 143,270 shares of our Common Stock (which represents the number of shares of Common Stock issuable upon exercise of outstanding stock options that are or will become exercisable on or prior to October 22, 2005 for the individuals in this table).

(a) The shares shown as beneficially owned by Apex Capital, LLC (Apex) include (i) 1,250,000 shares with respect to which Apex and Sanford J. Colen have shared voting power and shared investment power and (ii) 14,000 shares held of record by Mr. Colen of which he has sole voting power and sole investment power. Their address is 25 Orinda Way, Suite 300, Orinda, CA 94563. This information was as of December 31, 2004 and was obtained from a Schedule 13G/ A filed as of February 14, 2005.

(b) The shares reported are held by Buckingham Capital Management Incorporated, which has sole voting and investment power with respect to all shares reported. Its address is 750 Third Avenue, Sixth Floor, New York, NY 10017. This information was as of June 30, 2005 and was obtained from a Schedule 13G filed as of August 12, 2005.

(c) The shares reported are held by Columbia Wanger Asset Management, L.P. and its general partner for their clients in various fiduciary and agency capacities. One client, Columbia Acorn Trust, an investment company, has shared voting and investment power over 1,030,200 of the reported shares. Columbia

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Wanger Asset Management, L.P. has shared voting and investment power over all of the reported shares. The address for each of the parties is 227 West Monroe Street, Suite 3000, Chicago, IL 60606. This information was as of December 31, 2004 and was obtained from a Schedule 13G/ A filed as of February 11, 2005.

(d) The shares reported are held by SunTrust Banks, Inc. and its subsidiaries in various fiduciary and agency capacities and include (i) 686,556 shares with respect to which they have sole voting power, (ii) 51,000 shares with respect to which they have shared voting power, (iii) 592,113 shares with respect to which they have sole investment power and (iv) 355,614 shares with respect to which they have shared investment power. SunTrust disclaims beneficial interest in any of the shares reported. The address is 303 Peachtree Street, Suite 1500, Atlanta, GA 30308. This information was as of December 31, 2004 and was obtained from a Schedule 13G filed as of February 16, 2005.

(e) The shares reported are held Systematic Financial Management, L.P. and include (i) 590,227 shares with respect to which it has sole voting power and (ii) 910,227 shares with respect to which it has sole investment power. Its address is 300 Frank W. Burr Blvd., Glenpointe East, 7th Floor, Teaneck, NJ 07666. This information was as of December 31, 2004 and was obtained from a Schedule 13G filed as of February 14, 2005.

(f) Of this amount, Mr. Chubb has sole voting and investment power with respect to 5,233 shares, and 20,670 shares representing exercisable options.

(g) Of this amount, Mr. Lanier has sole voting and investment power with respect to 452,066 shares, sole voting and investment power with respect to 554,677 shares held by a charitable foundation of which Mr. Lanier is a trustee, sole voting and investment power with respect to 587,856 shares held by various trusts, and 79,200 shares of exercisable options.

(h) Of this amount, Mr. Lanier has sole voting and investment power with respect to 526,378 shares, and sole voting and investment power with respect to 73,182 shares held by trust.

(i) Of this amount, Mr. Margolis has sole voting and investment power with respect to 27,463 shares, and sole voting and investment power with respect to 9,092 shares held by trust.

(j) Of this amount, Mr. O Reilly has sole voting and investment power with respect to 12,712 shares, and 10,600 shares representing exercisable options.

(k) Of this amount, Mr. Setola has sole voting and investment power with respect to 4,500 shares, and 8,000 shares representing exercisable options.

(l) Of this amount, the executive officers not listed by name have sole voting and investment power with respect to 61,133 shares, sole voting and investment power with respect to 18,666 shares held by trust, and 24,800 shares representing exercisable options.

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EXECUTIVE OFFICERS

Identification of Executive Officers

The executive officers of our Company are as follows as of August 22, 2005:

Name	Age	Position Held
J. Hicks Lanier	65	Chairman and Chief Executive Officer
Michael J. Setola	47	President
Thomas C. Chubb III	41	Executive Vice President
S. Anthony Margolis	63	Group Vice President
Knowlton J. O Reilly	65	Group Vice President
John A. Baumgartner	62	Senior Vice President
K. Scott Grassmyer	44	Senior Vice President and Controller
J. Reese Lanier, Jr.	40	Senior Vice President and Treasurer
Christine B. Cole	56	Vice President
Anne M. Shoemaker	46	Vice President

All of our executive officers are elected by and serve at the discretion of either the Board or the Chairman of the Board.

Mr. J. Hicks Lanier has been Chairman and Chief Executive Officer of the Company since 1981. Mr. Lanier also served as President of the Company from 1977 until 2003. He is also a director of SunTrust Banks, Inc., Crawford & Company and Genuine Parts Company.

Mr. Michael J. Setola has served as President since 2003. Prior to joining the Company, Mr. Setola had been the Chairman and Chief Executive Officer of Salant Corporation since 1998. Salant Corporation filed a petition for relief under Chapter 11 of the Bankruptcy Code in 1998, and was reorganized in 1999.

Mr. Thomas C. Chubb III was appointed as Executive Vice President in 2004. From 1999 to 2004, he served as Vice President, General Counsel and Secretary.

Mr. S. Anthony Margolis has been a Group Vice President of the Company and Chief Executive Officer of Tommy Bahama Group, Inc. (formerly known as Viewpoint International, Inc.) since 2003. Prior to joining the Company, Mr. Margolis had been the Chief Executive Officer and President of Viewpoint International, Inc. since 1992.

Mr. Knowlton J. O Reilly has served as Group Vice President since 1978.

Mr. John A. Baumgartner was appointed as Senior Vice President in 2004. From 1992 to 2004, he served as Vice President.

Mr. K. Scott Grassmyer was appointed as Senior Vice President in 2004 and remains Controller. From 2003 to 2004, he served as Vice President and Controller. From 2002 to 2003, he served as Controller. Prior to joining the Company, he served as Senior Vice President and Chief Financial Officer of Duck Head Apparel Company, Inc., an apparel manufacturer, since 1997.

Mr. J. Reese Lanier, Jr. was appointed as Senior Vice President in 2004 and remains Treasurer. From 2003 to 2004, he served as Vice President and Treasurer. From 2000 to 2003, he served as Treasurer.

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Ms. Christine B. Cole was appointed as Vice President in 2004. Prior to joining the Company, Ms. Cole had been the Vice President of Reed Business Information, Inc., a provider of information and communications for a diverse range of business sectors, since 1999.

Ms. Anne M. Shoemaker was appointed as Vice President in 2004. From 1995 to 2004, she served as Director of Credit and Internal Audit.

Ethical Conduct Policy for Senior Financial Officers

Our Board of Directors has adopted a code of ethical conduct for our senior financial officers, including, among others, our principal executive officer (our CEO), our principal financial officer (our Executive Vice President), and our principal accounting officer (our Controller). These individuals are expected to adhere at all times to this code of ethical conduct. We have posted this code of ethical conduct on our Internet website at *www.oxfordinc.com.*

Failure to comply with this code of ethical conduct is a serious offense and will result in appropriate disciplinary action. Our Board and our Audit Committee each has the authority to independently approve, in their sole discretion, any such disciplinary action as well as any amendment to and any material departure from a provision of this code of ethical conduct. We will disclose on our Internet website at *www.oxfordinc.com,* to the extent and in the manner permitted by Item 5.05 of Form 8-K under Section 13 of the Exchange Act, the nature of any amendment to this code of ethical conduct (other than technical, administrative, or other non-substantive amendments), our approval of any material departure from a provision of this code of ethical conduct, and our failure to take action within a reasonable period of time regarding any material departure from a provision of this code of ethical conduct that has been made known to any of the executive officers noted above.

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EXECUTIVE COMPENSATION

Summary Compensation Table

The table below shows the compensation earned during fiscal 2005, 2004, and 2003 by our CEO and our four other most highly compensated executive officers who were serving at the end of fiscal 2005. These individuals are called the **named executive officers**.

Summary Compensation Table

				Long-Term Compensation Awards		
		Annual Compensation			Securities	
Name and Principal Position	Year	Salary ($)(1)	Bonus ($)	Restricted Stock ($)(2)	Underlying Options (# shares)(3)	All Other Compensation($)(4)
		0.19	—			
California minimum medical loss ratio change [8]	—	(0.76)	—			
Debt extinguishment [9]	—	0.04	—			
Adjusted Diluted EPS from continuing operations	$ 5.03	$4.43	$ 3.14			

(1) In connection with the favorable impact of the Tax Cuts and Jobs Act (Income Tax Reform) passed in late 2017 and the additional revenue associated with the California minimum medical loss ratio (MLR) change in 2016, the Company made charitable commitments to its foundation in 2017 and 2016, respectively.

(2) The income tax effects of adjustments are based on the effective income tax rates applicable to adjusted (non-GAAP) results. There is no additional income tax effect from Income Tax Reform.

(3) Amortization of acquired intangible assets per diluted share is net of an income tax benefit of $0.32, $0.33, and $0.08 for the years ended December 31, 2017, 2016 and 2015, respectively.

(4) Acquisition related expenses per diluted share are net of an income tax benefit of $0.04, $0.45 and $0.08 for the years ended December 31, 2017, 2016 and 2015, respectively.

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(5) The Penn Treaty assessment expense per diluted share is net of an income tax benefit of $0.12 for the year ended December 31, 2017.

(6) The cost sharing reduction (CSR) expense per diluted share is net of an income tax benefit of $0.04 for the year ended December 31, 2017.

(7) The charitable contributions per diluted share are net of an income tax benefit of $0.09 and $0.11 for the years ended December 31, 2017 and 2016, respectively.

(8) The impact associated with the retroactive contract amendment received in the fourth quarter of 2016 that changed the minimum MLR calculation per diluted share is net of the income tax expense of $(0.43) for the year ended December 31, 2016.

(9) The debt extinguishment cost per diluted share is net of the income tax benefit of $0.03 for the year ended December 31, 2016.

	Year Ended December 31,		
	2017	2016	2015
GAAP selling, general and administrative expenses	$4,446	$3,676	$1,802
Acquisition related expenses	20	234	27
Penn Treaty assessment expense	56	—	—
Charitable contribution	40	50	—
Adjusted selling, general and administrative expenses	$4,330	$3,392	$1,775

	Year Ended December 31,	
	2017	2016
Net earnings from continuing operations attributable to Centene Corporation	$828	$559
Income tax expense	326	599
Interest expense	255	217
Depreciation and amortization	362	281
Non-cash stock compensation expense	135	148
Adjusted EBITDA [1]	$1,906	$1,804

(1) Adjusted EBITDA represents net earnings attributable to Centene Corporation excluding income tax expense, interest expense, depreciation, amortization (excluding senior note premium amortization) and non-cash compensation expense.

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PART I

ITEM 1. Business

OVERVIEW

We are a diversified, multi-national healthcare enterprise that provides a portfolio of services to government sponsored and commercial healthcare programs, focusing on under-insured and uninsured individuals. We provide member-focused services through locally based staff by assisting in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions. We also provide education and outreach programs to inform and assist members in accessing quality, appropriate healthcare services. We believe our local approach, including member and provider services, enables us to provide accessible, quality, culturally-sensitive healthcare coverage to our communities. Our health management, educational and other initiatives are designed to help members best utilize the healthcare system to ensure they receive appropriate, medically necessary services and effective management of routine, severe and chronic health problems, resulting in better health outcomes. We combine our decentralized local approach for care with a centralized infrastructure of support functions such as finance, information systems and claims processing.

In September 2017, we signed a definitive agreement under which Fidelis Care will become our health plan in New York State. Under the terms of the agreement, we will acquire substantially all of the assets of Fidelis Care for $3.75 billion, subject to certain adjustments.

We operate in two segments: Managed Care and Specialty Services. Our Managed Care segment provides health plan coverage to individuals through government subsidized and commercial programs including Medicaid, the State Children’s Health Insurance Program (CHIP), Long-Term Services and Supports (LTSS), Medicare, Foster Care, Supplemental Security Income Program, also known as the Aged, Blind or Disabled, or collectively ABD, and Medicare-Medicaid Plans (MMP), which cover beneficiaries who are dually eligible for Medicare and Medicaid. In addition, our commercial operations, which include our members through the Health Insurance Marketplace, are included within the Managed Care segment. Our Specialty Services segment consists of our specialty companies offering diversified healthcare services and products to state programs, correctional facilities, healthcare organizations, employer groups, military service members and their families, and other commercial organizations, as well as to our own subsidiaries. For the year ended December 31, 2017, our Managed Care and Specialty Services segments accounted for 95% and 5%, respectively, of our total external revenues.

Our membership totaled 12.2 million as of December 31, 2017. For the year ended December 31, 2017, our total revenues and net earnings from continuing operations attributable to Centene were $48.4 billion and $828 million, respectively, and our total cash flow from operations was $1.5 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 corporate office is located at 7700 Forsyth Boulevard, St. Louis, Missouri 63105, and our telephone number is (314) 725-4477. Our stock is publicly traded on the New York Stock Exchange under the ticker symbol “CNC.”

INDUSTRY

We provide a full spectrum of managed healthcare products and services, primarily through Medicaid (which includes CHIP, LTSS, Foster Care, ABD and MMP), Medicare, and commercial products. We currently have operations domestically and internationally.

Medicaid

Established in 1965, Medicaid is the largest publicly funded program in the United States, and provides health insurance to low-income families and individuals with disabilities. Authorized by Title XIX of the Social Security Act, Medicaid is an entitlement program funded jointly by the federal and state governments and administered by the states. The majority of funding is provided at the federal level. 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. Historically, children have represented the largest eligibility group. Many states have selected Medicaid managed care as a means of delivering quality healthcare and controlling costs. We refer to these states as mandatory managed care states.

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Established in 1972 and authorized by Title XVI of the Social Security Act, ABD covers low-income persons with chronic physical disabilities or behavioral health impairments. ABD beneficiaries represent a growing portion of all Medicaid recipients. In addition, ABD recipients typically utilize more services as a result of their health status.

The Balanced Budget Act of 1997 created CHIP to help states expand coverage primarily to children whose families earned too much to qualify for Medicaid, yet not enough to afford private health insurance. Costs related to the largest eligibility group, children, are primarily composed of pediatrics and family care. These costs tend to be more predictable than those associated with other healthcare issues which predominantly affect the adult population.

LTSS is a Medicaid product that covers Institutional/Residential Care (Nursing Facilities, Intermediate Care Facilities) and Home and Community Based Services (HCBS) for beneficiaries requiring assistance with their activities of daily living, such as bathing, dressing and transferring. The most common HCBS services include personal care, adult day care, non-emergent transportation, home-delivered meals and personal emergency response systems. LTSS services are provided for individuals requiring nursing home level of care, receiving waiver services, or entitled to state Medicaid LTSS benefits. The largest group receiving LTSS, by spending, are older individuals and individuals with physical disabilities ($98 billion in 2015), followed by individuals with intellectual and developmental disabilities ($44 billion in 2015), those with serious mental illness and/or serious emotional disturbance ($9 billion in 2015) and other populations ($7 billion in 2015). States are increasingly turning to managed care as a solution to provide coordinated, holistic care to their LTSS beneficiaries. According to the National Association of States United for Aging and Disabilities, 20 states utilize some form of LTSS up from eight in 2004.

The majority of youth and children in foster care qualify for Medicaid, most commonly through Title IV-E of the Social Security Act, which provides funding to support safe and stable out-of-home care for children who are removed from their homes. The federal government has enacted legislation establishing guidelines and 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 state Medicaid. In addition, the Affordable Care Act requires states to make former foster care children eligible for Medicaid until they reach the age of 26, provided that they turned 18 while in foster care, and were enrolled in Medicaid at that time.

CMS estimated the total Medicaid market was approximately $566 billion in 2016, and estimated the market will grow to $929 billion by 2025. Medicaid spending increased by 3.9% in 2016 and is projected to increase at an average annual rate of 5.7% between 2017 and 2025.

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 rooms, which tends to be more expensive. As a result, many states have found that the costs of providing Medicaid benefits have increased while the medical outcomes for the recipients remained unsatisfactory.

We believe recognition of the value of managed care as a means of delivering improved health outcomes for Medicaid beneficiaries and effectively controlling costs will continue to strengthen. A growing number of states have mandated that their Medicaid recipients enroll in managed care plans. Other states are considering moving to a mandated managed care approach. As a result, we believe a significant market opportunity exists for managed care organizations with operations and programs focused on the distinct socio-economic, cultural and healthcare needs of the uninsured population and the Medicaid, CHIP, LTSS, Foster Care and ABD populations.

Medicare

We contract with CMS under the Medicare Advantage program to provide Medicare Advantage products directly to Medicare beneficiaries as well as through employer and union groups. We provide or arrange healthcare benefits for services normally covered by Medicare, plus a broad range of healthcare benefits for services not covered by traditional Medicare, usually in exchange for a 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. Many of our Medicare Advantage members pay no monthly premium to us for these additional benefits.

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We provide a wide range of Medicare products, including Medicare Advantage plans with and without prescription drug coverage and Medicare supplement products that supplement traditional fee-for-service Medicare coverage. Our subsidiaries have a number of contracts with CMS under the Medicare Advantage program authorized under Title XVIII of the Social Security Act.

A portion of Medicare beneficiaries are dual-eligible, low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare. According to CMS, there were approximately 10.7 million dual-eligible enrollees in 2017. These dual-eligible members may receive assistance from Medicaid for benefits, such as nursing home care, HCBS, and/or assistance with Medicare premiums and cost sharing. Dual-eligibles also use more services due to their tendency to have more chronic health issues. We serve dual-eligibles through our ABD, LTSS, MMP and Medicare Advantage Dual Special Needs Plan lines of business.

CMS developed the Medicare Advantage Star ratings system to help consumers choose among competing plans, awarding between 1.0 and 5.0 stars to Medicare Advantage plans based on performance in certain measures of quality. The Star ratings are used by CMS to award quality bonus payments to Medicare Advantage plans. Beginning with the 2014 Star ratings (calculated in 2013), Medicare Advantage plans are required to achieve a minimum of 4.0 Stars to qualify for a quality bonus payment. The methodology and measures included in the Star ratings system can be modified by CMS annually and Star ratings thresholds are based on performance of Medicare Advantage plans nationally.

CMS estimated the total Medicare market was approximately $679 billion in 2016, and estimate the market will grow to approximately $1.3 trillion by 2025. Medicare spending increased 5.1% in fiscal 2016 and is projected to increase at an average annual rate of 7.3% between 2017 and 2025.

Commercial

We offer commercial healthcare products to individuals and large and small employer groups as well as products to individuals through the Health Insurance Marketplace. Our health maintenance organization (HMO) plans offer comprehensive benefits generally for a fixed fee or premium that does not vary with the extent or frequency of medical services actually received by the member. We offer HMO 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. When an individual enrolls in one of our HMO plans, he or she selects a primary care physician (PCP) from among the physicians participating in our network. Our preferred provider organization (PPO) plans offer coverage for services received from any healthcare provider, with benefits generally paid at a higher level when care is received from a participating network provider. Coverage typically is subject to deductibles and copayments or coinsurance. Our point of service (POS) plans and our elect open access (EOA) plans blend the characteristics of HMO, PPO and indemnity plans. Members can have comprehensive HMO-style benefits for services received from participating network providers with lower copayments (particularly within the medical group), but also have coverage, generally at higher copayment or coinsurance levels or with coverage limitations, for services received outside the network. Our Exclusive Provider Organization (EPO) plans and Healthcare Service Plans (HSPs) similarly blend elements of traditional HMO and PPO plans.

In 2010, the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act, collectively referred to as the Affordable Care Act (ACA), were enacted. While the constitutionality of the ACA was subsequently challenged in a number of legal actions, in June 2012, the Supreme Court upheld the constitutionality of the ACA, with one limited exception relating to the Medicaid expansion provision (Medicaid Expansion). The Supreme Court held that states could not be required to expand Medicaid and risk losing all federal money for their existing Medicaid programs. Under the ACA, Medicaid coverage was expanded

to all individuals under age 65 with incomes up to 138% of the federal poverty level beginning January 1, 2014, subject to the states' elections. The federal government paid the entire costs for Medicaid Expansion coverage for newly eligible beneficiaries from 2014 through 2016, and 95% of the costs in 2017. Assuming that the current program remains in effect unchanged, in 2018 the federal share is scheduled to decline to 94%; in 2019 it would be 93%; and it would be 90% in 2020 and subsequent years.

Health Insurance Marketplaces are a key component of the ACA and provide an opportunity for individuals and small businesses to obtain health insurance. States have the option of operating their own Marketplace or partnering with the federal government. States choosing neither option currently default to a federally-facilitated Marketplace. Premium and cost sharing subsidies are available to make coverage more affordable and access to Marketplaces 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 families without access to other coverage and with incomes between 100-400% of the federal poverty level to help them purchase insurance through the Marketplaces. These subsidies are offered on a sliding scale basis.

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International

We currently have a growing international presence in Spain and the United Kingdom. Our joint venture in Spain, Ribera Salud S.A. (Ribera Salud), is a health management group mainly operating in the health administrations concession sector. Ribera Salud also has other controlling and noncontrolling interests in Spain, Latin America, and Slovakia. In the United Kingdom, we own a controlling interest in The Practice (Group) Limited (TPG), one of the largest provider networks in the United Kingdom. TPG delivers medical and community based services in the primary care sector of the National Health Service (NHS), which is the publicly funded, national healthcare system for England.

OUR COMPETITIVE STRENGTHS

Our approach is based on the following key competitive strengths:

- Expertise in Government Sponsored Programs. For more than 30 years, we have developed a specialized government services expertise that has helped us establish and maintain relationships with members, providers and state governments. We have implemented programs developed to achieve savings for state governments and improve medical outcomes for members by reducing inappropriate emergency room use, inpatient days and high cost interventions, as well as by managing care of chronic illnesses. We work with state agencies in order to maximize the effectiveness of their programs. Our approach is to accomplish this while maintaining adequate levels of provider compensation and protecting our profitability.

- Strong Historic Operating Performance. We have increased revenues as we have grown in existing markets, expanded into new markets and broadened our product offerings. We entered the Wisconsin market in 1984 as a single health plan and have grown to serve 29 states. Our operating performance has been demonstrated by the following:

	2017	2016	% Change 2016 - 2017
Total membership (in millions)	12.2	11.4	7%
Total revenues ($ in billions)	$48.4	$40.6	19%
Net earnings from continuing operations attributable to Centene Corporation ($ in millions)	$828	$559	48%
Diluted earnings per share (EPS)	$4.69	$3.41	38%
Adjusted Diluted EPS	$5.03	$4.43	14%
Adjusted EBITDA	$1,906	$1,804	6%

For the year ended December 31, 2017, total revenues of $48.4 billion produced a five year Compound Annual Growth Rate (CAGR) of 43%.

- Financial Strength and Scale. Our size and scale allow us to grow, diversify and invest in our businesses through strategic acquisitions and investments in technology and other resources that support our business and help us navigate the changing healthcare landscape.

- Innovative Technology and Scalable Systems. The ability to access data and translate it into meaningful information is essential to operating across a multi-state service area in a cost-effective manner. Our centralized information systems support our core processing functions under a set of integrated databases and are designed to be both replicable and scalable to accommodate organic growth and growth from acquisitions. We continue to enhance our systems in order to leverage the platform we have developed for our existing states for configuration into new states or health plan acquisitions. We believe our predictive modeling technology enables our medical management

operations to proactively case and disease manage specific high risk members. It can recommend medical care opportunities using a mix of company defined algorithms and evidence based medical guidelines. Interventions are determined by the clinical indicators, the ability to improve health outcomes, and the risk profile of members. We believe our integrated approach helps to assure that consistent sources of claim and member information are provided across all of our health plans. Our membership and claims processing system is capable of expanding to support additional members in an efficient manner.

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Diversified Business Lines. We continue to broaden our service offerings to address areas that we believe have been traditionally under-served by Medicaid managed care organizations. In addition to our Medicaid and Medicaid-related managed care services, our service offerings include behavioral health management, care management software, correctional healthcare services, dental benefits management, commercial programs, home-based primary care services, life and health management, vision benefits management, pharmacy benefits management, specialty pharmacy and telehealth services. With the acquisition of Health Net, we further broadened our service offerings in 2016, which added government-sponsored care under its federal contracts with the Department of Defense (DoD) and the U.S. Department of Veterans Affairs (VA), as well as Medicare Advantage. Through the utilization of a multi-business line approach, we are able to improve the quality of care, improve outcomes, diversify our revenues and help control our medical costs.

Localized Approach with Centralized Support Infrastructure. We take a localized approach to managing our subsidiaries, including provider and member services. This approach enables us to facilitate access by our members to high quality, culturally sensitive healthcare services. Our systems and procedures have been designed to address these community-specific challenges through outreach, education, transportation and other member support activities. For example, our community outreach programs work with our members and their communities to promote health and self-improvement through education on how best to access care. We complement this localized approach with a centralized infrastructure of support functions such as finance, information systems and claims processing, which allows us to minimize selling, general and administrative (SG&A) expenses and to integrate and realize synergies from acquisitions. We believe this combined approach allows us to efficiently integrate new business opportunities in both Medicaid and specialty services while maintaining our local accountability and improved access.

Quality and Innovation. Our innovative medical management programs focus on improving quality of care in areas that have the greatest impact on our members. We concentrate on serving the whole person to impact outcomes and costs. We recognize the importance of member-focused delivery of quality managed care services and have developed award winning education and outreach programs including the CentAccount program, On.Demand Diabetes, Start Smart For Your Baby, and MemberConnections.

OUR BUSINESS STRATEGY

Key components of our current business strategy include:

Increase Penetration of Existing State Markets. We seek to continue to increase our Medicaid, Medicare and Health Insurance Marketplace membership in states in which we currently operate through alliances with key providers, outreach efforts, development and implementation of community-specific products and acquisitions. For example, in 2017, we began providing managed care services to MO HealthNet Managed Care beneficiaries under an expanded statewide contract. Also, in 2017, we expanded our Medicare Advantage footprint into four of our existing states. In 2018, we expanded Medicare Advantage further into nine of our existing states.

Diversify Business Lines. We seek to broaden our business lines into areas that complement our existing business to enable us to grow and diversify our revenues. In 2017, we served managed care members in 27 states through approximately 300 product solutions. We are constantly evaluating new opportunities for expansion both domestically and abroad. For example, in 2016, we acquired Health Net, which broadened our service offerings and added government-sponsored care. We employ a disciplined acquisition strategy that is based on defined criteria including internal rate of return, accretion to earnings per share, market leadership and compatibility with our information systems. We engage our executives in the relevant operational units or functional areas to ensure consistency between the diligence and integration process.

- Address Emerging State Needs. We work to assist the states in which we operate in addressing the operating challenges they face. We seek to assist the states in balancing premium rates, benefit levels, member eligibility, policies and practices, provider compensation and minimizing fraud, waste, and abuse. By helping states structure appropriate programs to cover a wide range of populations including Medicaid, CHIP, LTSS, ABD, Intellectual or Developmental Disabilities (IDD), behavioral health and specialty services, among others. We seek to ensure that we are able to continue to provide those services on terms that achieve targeted gross margins, provide an acceptable return and grow our business.

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- Develop and Acquire Additional Markets. We continue to leverage our experience to identify and develop new domestic and international markets by seeking both to acquire existing business and to build our own operations. Domestically, we focus expansion in states where Medicaid recipients are mandated to enroll in managed care organizations because we believe member enrollment levels are more predictable in these states. In addition, we provide solutions to states looking to deliver the highest quality of care within their budgetary constraints. In 2016, we increased our ownership interest to 75% in The Practice (Group) Limited (TPG), one of the largest provider networks for NHS England. In 2017, we expanded into Maryland, Nebraska and Nevada. Also in 2017, we signed a definitive agreement under which Fidelis Care will become our health plan in New York State.

- Leverage Established Infrastructure to Enhance Operating Efficiencies. We intend to continue to invest in infrastructure to further drive efficiencies in operations and to add functionality to improve the service provided to members and other organizations at a low cost. Information technology (IT) investments complement our overall efficiency goals by increasing the automated processing of transactions and growing the base of decision-making analytical tools. We believe that our centralized functions and common systems enable us to add members and markets quickly and economically.

- Maintain Operational Discipline. We seek to operate in markets that allow us to meet our internal metrics including membership growth, plan size, market leadership and operating efficiency. We use multiple techniques to monitor and reduce our medical costs, including on-site hospital review by staff nurses and involvement of medical management in significant cases. Our executive dashboard is utilized to quickly identify cost drivers and medical trends. Our management team regularly evaluates the financial impact of proposed changes in provider relationships, contracts, changes in membership and mix of members, potential state rate changes and cost reduction initiatives. We may divest contracts or health plans in markets where the environment, over a long-term basis, does not allow us to meet our targeted performance levels. For example, due to under performance, we exited the Arizona individual PPO business, effective January 1, 2017. In addition, in 2016, we took various rate and product design actions for 2017 to address issues and improve profitability in connection with certain lines of business acquired with the Health Net Acquisition.

Substantially all of our revenues are derived from operations within the United States and its territories, and all of our long-lived assets are based in the United States and its territories. We generally receive a fixed premium per member per month pursuant to our state contracts. Our managed care subsidiaries in California and Texas had revenues from their respective state governments that each exceeded 10% of our consolidated total revenues in 2017. In addition, the federal government is a significant customer to our Specialty Services segment due to our Federal Services business.

MANAGED CARE

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 in working with state governments. Among the benefits we are able to provide to the states with which we contract are:

- Significant cost savings and budget predictability compared to state paid reimbursement for services. We bring experience relating to quality of care improvement methods, utilization management procedures, an efficient claims payment system, and provider performance reporting, as well as managers and staff experienced in using these key elements to improve the quality of and access to care. We generally receive a contracted premium on a per member basis and are responsible for the medical costs and, as a result, provide budget predictability.

- Data-driven approaches to balance cost and verify eligibility. We seek to ensure effective outreach procedures for new members, then educate them and ensure they receive needed services as quickly as possible. Our IT department has created mapping/translation programs for loading membership and linking membership eligibility status to all of Centene's subsystems. We utilize predictive modeling technology to proactively case and disease manage specific high risk members. In addition, we have developed Centelligence, our enterprise data warehouse system to provide a seamless flow of data across our organization, enabling providers and case managers to access information, apply analytical insight and make informed decisions.

- Establishment of realistic and meaningful expectations for quality deliverables. We have collaborated with state agencies in redefining benefits, eligibility requirements and provider fee schedules with the goal of maximizing the number of individuals covered through Medicaid.

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Managed care expertise in government subsidized programs. Our expertise in Medicaid has helped us establish and maintain strong relationships with our constituent communities of members, providers and state governments. We provide access to services through local providers and staff that focus on the cultural norms of their individual communities. To that end, systems and procedures have been designed to address community-specific challenges through outreach, education, transportation and other member support activities.

- Improved quality and medical outcomes. We have implemented programs to enhance the ability of providers to improve the quality of healthcare delivered to our members including On.Demand Diabetes, Start Smart for your Baby, Living Well With Sickle Cell and The CentAccount Program.

Timely payment of provider claims. We are committed to ensuring that our information systems and claims payment systems meet or exceed state requirements. We continuously endeavor to update our systems and processes to improve the timeliness of our provider payments.

Provider outreach and programs. Our health plans have adopted a physician-driven approach where network providers are actively engaged in developing and implementing healthcare delivery policies and strategies. We prepare provider comparisons on a severity adjusted basis. This approach is designed to eliminate unnecessary costs, improve services to members and simplify the administrative burdens placed on 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 increase opportunities for successful outcomes for members. This experience has led to partnerships with specialized networks and community advocates as states transition to managed care programs for vulnerable and complex populations.

Responsible collection and dissemination of utilization data. We gather utilization data from multiple sources, allowing for an integrated view of our members' utilization of services. These sources include medical, vision and behavioral health claims and encounter data, pharmacy data, dental vendor claims and authorization data from the authorization and case management system utilized by us to coordinate care.

Timely and accurate reporting. Our information systems have reporting capabilities which have been instrumental in identifying the need for new and/or improved healthcare and specialty programs. For state agencies, our reporting capability is important in demonstrating an auditable program.

- Fraud, waste and abuse prevention. We have several systems in place to help identify, detect and investigate potential waste, abuse and fraud including pre and post payment review software. We collaborate with state and federal agencies and assist with investigation requests. We use nationally recognized standards to benchmark our processes.

Member Programs and Services

We recognize the importance of member-focused delivery of quality managed care services. Our locally-based staff assists members in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions. While covered healthcare benefits vary from customer to customer and program to program, our health plans generally provide the following services:

- primary and specialty physician care
- inpatient and outpatient hospital care

- emergency and urgent care
- prenatal care
- laboratory and x-ray services
- home-based primary care
- transportation assistance
- vision care
- dental care

- immunizations
- prescriptions and limited over-the-counter drugs
- specialty pharmacy
- provision of durable medical equipment
- behavioral health and substance abuse services
- 24-hour nurse advice line
- therapies
- social work services
- care coordination

We also provide a comprehensive set of education and outreach programs to inform, assist and incentivize members to access quality, appropriate healthcare services in an efficient manner. Many of these programs have been recognized with awards for their excellence in education, outreach and/or case management techniques. These awards include Case In Point, Hermes Awards, U.S. Environmental Protection Agency and National Health Information Awards.

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- Start Smart For Your Baby, or Start Smart, is our award winning prenatal and infant health program designed to increase the percentage of pregnant women receiving early prenatal care, reduce the incidence of low-birth-weight babies, identify high-risk pregnancies, increase participation in the federal Women, Infant and Children program, prevent hospital admissions in the first year of life and increase well-child visits.

- Connections Plus is a cell phone program developed for high-risk members who have limited or no safe and reliable access to telephone. This program seeks to eliminate lack of safe, reliable access to a telephone as a barrier to coordinating care, thus reducing avoidable adverse events such as inappropriate emergency room utilization, hospital admissions and premature birth.

- MemberConnections is a community face-to-face outreach and education program designed to create a link between the member and the provider and help identify potential challenges or risk elements to a member's health, such as nutritional challenges and health education shortcomings.

- The ScriptAssist for Hepatitis C Adherence Program seeks to empower patients towards Hepatitis C virus treatment success through a series of telephonic interventions. Goals of the program include preventing premature treatment discontinuation due to medication side effects and access to therapy. Through its family of companies, Envolve clinicians and AcariaHealth patient care coordinators collaborate throughout a patient’s treatment course to ensure appropriate therapy management and regimen access.

- Health Initiatives for Children is aimed at educating child members on a variety of health topics. In order to empower and educate children, we have partnered with a nationally recognized children's author to develop our own children's book series on topics such as obesity prevention and healthy eating, asthma, diabetes, foster care, the ills of smoking, anti-bullying and heart health.

- Health Initiatives for Teens is aimed at empowering, educating and reinforcing life skills with our teenage members. We have developed an educational series that addresses health issues, dealing with chronic diseases including diabetes and asthma, as well as teen pregnancy.

- Living Well with Sickle Cell is our innovative program that assists with coordination of care for our sickle cell members. Our program ensures that sickle cell members have established a medical home and work on strategies to reduce unnecessary emergency room visits through proper treatment to control symptoms and chronic complications, as well as promote self-management.

- My Route for Health is our adult educational series used with our case management and disease management programs. The topics of this series include how to manage asthma, Chronic Obstructive Pulmonary Disease (COPD), diabetes, heart disease and HIV.

- The Diabetes Management Program is a robust holistic program designed to improve the quality of life for our members living with diabetes. The program employs advanced analytics to identify members and provide individualized diabetes-related education and health assessments, support with self-management, and assistance accessing care.

- On.Demand Diabetes is a diabetes management support product designed to eliminate diabetic supply waste while increasing compliance and improving health outcomes for members with diabetes. On.Demand provides cellular-enabled blood glucose meters and test strips to the testing diabetic population. On.Demand automatically monitors all member tests and provides an appropriate level of intervention in the event of dangerous glucose readings

or member non-compliance. Additionally, On.Demand's proprietary algorithm analyzes each member's testing patterns and automatically replenishes testing supplies to ensure there are no gaps in the member's ability to effectively monitor their condition.

- Community Health Record, our patient-centric electronic database, collects patient demographic data, clinician visit records, dispensed medications, vital sign history, lab results, allergy charts, and immunization data. Providers can directly input additional or updated patient data and documentation into the database. All information is accessible anywhere, anytime to all authorized users, including health plan staff, greatly facilitating coordinated care among providers.

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- The CentAccount Program offers members financial incentives for performing certain healthy behaviors. The incentives are delivered through a restricted-use prepaid debit card. This incentive-based approach effectively increases the utilization of preventive services while strengthening the relationships between members and their primary care providers.

- The Asthma Management Program integrates a hands-on approach with a flexible outreach methodology that can be customized to suit different age groups and populations affected by asthma. We provide proactive identification of members, stratification into appropriate levels of intervention including home visits, culturally sensitive education, and robust outcome reporting. The program also includes aggressive care coordination to ensure patients have basic services such as transportation to the doctor, electricity to power the nebulizer, and a clean, safe home environment.

- Fluvention is an outreach program aimed at educating members on preventing the transmission of the influenza virus by encouraging members to get the seasonal influenza vaccines and take everyday precautions to prevent illness.

- Preventive Care Programs are designed to educate our members on the benefits of Early and Periodic Screening, Diagnosis and Treatment, or EPSDT, services. We have a systematic program of communicating, tracking, outreach, reporting and follow-through that promotes state EPSDT programs.

- Readmission Reduction Program utilizes a proprietary scoring methodology to evaluate members' risks on preventable readmissions. Members with higher risk scores are identified at the point of admission to an acute care setting, then concurrently managed during the in-patient stay, and followed up with post discharge outreach to provide effective transition of care.

- Clinical Programs Library (CPL) is a highly collaborative initiative that empowers partners across the organization to develop evidence based clinical programs to promote best practice information sharing, and to establish measurable outcomes for clinical studies. The CPL also serves as a repository of enterprise pilots and programs intended to improve the member's health outcomes.

- Promotores Health Network (PHN) is a volunteer-driven community health network designed to improve the community's health through health education specific to health conditions impacting their community and providing guidance and linkage to healthcare services and local resources. PHN provides face-to-face education to members where they live, shop, worship and congregate.

- myStrength ("The health club for your mind") is a web and mobile self-help resource to manage depression, anxiety, substance use, and chronic pain. myStrength empowers members to be active participants in their journey to becoming and staying mentally and physically healthy.

- Opioid Risk Classification Algorithm (ORCA) is designed to identify members at risk for an opioid abuse diagnosis based on a series of critical social and clinical indicators. Providers will leverage this risk score to flag members for case management and other appropriate interventions. High risk members identified by ORCA will receive educational outreach to provide evidenced-based resources to support pain addiction.

Providers

For each of our service areas, we establish a provider network consisting of primary and specialty care physicians, hospitals and ancillary providers. Our network of primary care physicians is a critical component in care delivery, management of costs and the attraction and retention of new members. Primary care physicians include family and general practitioners, pediatricians, internal medicine physicians and obstetricians and gynecologists. Specialty care

physicians provide medical care to members generally upon referral by the primary care physicians. Specialty care physicians include, but are not limited to, orthopedic surgeons, cardiologists and otolaryngologists. We also provide education and outreach programs to inform and assist members in accessing quality, appropriate healthcare services.

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 usually are for one to three-year periods 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, depending on the product (e.g., Medicaid or Medicare). We pay providers under a variety of methods, including fee-for-service, capitation arrangements, and value-based arrangements.

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- Under our fee-for-service contracts with providers, we pay a negotiated fee for covered services. 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. A provider group's financial instability or failure to pay secondary providers for services rendered could lead secondary providers to demand payment from us, even though we have made our regular capitated payments to the provider group. Depending on state law and the regulatory environment, it may be necessary for us to pay such claims.

Under value-based arrangements, providers are paid under a capitated or fee-for-service arrangement. The arrangement, however, contains provisions for additional payments to the providers or reimbursement from the providers based upon cost and quality measures.

In addition, we maintain a network of qualified physicians, facilities, and ancillary providers in the prime service areas of our TRICARE contract. Services are provided on a fee-for-service basis. We also maintain a provider network in support of VA's Patient Centered Community Care (PC3) program.

We work with physicians to help them operate efficiently by providing financial and utilization information, physician and patient educational programs and disease and medical management programs. Our programs are also designed to help the 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 physicians serve on local committees that assist us in implementing preventive care programs, managing 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 that, in turn, have helped to increase our membership base. The following are among the services we provide to support physicians:

- Provider Engagement Performance Tools and Processes lead to measurable improvements in quality and health outcomes, healthcare costs, and member satisfaction. High quality and performance levels are important as our key customers are increasingly using performance-based measures to select and pay health plans. We have rolled out a suite of network performance tools for use by physicians and other providers which monitor the outcomes and care gaps of their individual patient panel. Our specialists 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.

Integrated Care Model is member-centric and managed by one care manager assigned to a member who looks at the total 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 outcomes and improvement in member satisfaction.

Provider Portal provides claims and eligibility research, prior authorizations, member panels, care gaps, patient analytics, and provider analytics meant to drive provider engagement and better patient outcomes. Performance is supplied via a secure, user-friendly web-based provider portal.

Our contracted physicians also benefit from several of the services offered to our members, including the MemberConnections, EPSDT case management and health management programs. For example, the MemberConnections staff facilitates doctor/patient relationships by connecting members with physicians, the EPSDT programs encourage routine checkups for children with their physicians and the health management programs assist physicians in managing their patients with chronic disease.

Where appropriate, our health plans contract with our specialty services organizations to provide services and programs such as behavioral health management, care management software, dental benefits management, home-based primary care services, life and health management, managed vision, pharmacy benefits management, specialty pharmacy and telehealth services. When necessary, we also contract with third-party providers on a negotiated fee arrangement for physical therapy, home healthcare, dental, diagnostic laboratory tests, x-ray examinations, transportation, ambulance services and durable medical equipment.

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Quality Management

Our medical management programs focus on improving quality of care in areas that have the greatest impact on our members. We employ strategies, including health management and complex case management, which are adjusted for implementation in our individual markets by a system of physician committees chaired by local physician leaders. This process promotes physician participation and support, both critical factors in the success of any clinical quality improvement program.

We have implemented specialized information systems to support our medical quality management activities. Information is drawn from our data warehouse, clinical databases and our membership and claims processing system to identify opportunities to improve care and to track the outcomes of the interventions implemented to achieve those improvements. Some examples of these programs include:

- use of nationally recognized Interqual or Milliman criteria to help ensure our members receive the right level of care in the most appropriate setting;
- pre-authorized high-risk mediation and services that are commonly over or inappropriately prescribed;
- member education and the provision of appropriate and easily accessed urgent care services to help members avoid unnecessary and costly emergency room visits and improve their healthcare experience;
- emphasis on care management and care coordination where clinicians, such as nurses and social workers who are employed to assist high-risk and other selected members with the coordination of healthcare services that meet their specific needs;
- disease management for chronic illnesses, such as asthma and diabetes through a comprehensive, multidisciplinary and collaborative approach;
- prenatal case management for women with high-risk pregnancies to help them deliver full, healthy infants; and
- pharmacy treatment compliance programs driven by evidence-based clinical policies and focused on identifying the appropriate medication in the correct dose, delivered in an efficient format and utilized for the correct duration.

We provide reporting on a regular basis using our data warehouse. State and Health Employer Data and Information Set (HEDIS) reporting constitutes the core of the information base that drives our clinical quality performance efforts. This reporting is monitored by Plan Quality Improvement Committees and our corporate medical management and quality improvement teams.

In an effort to ensure the quality of our provider networks, we verify the credentials and background of our providers using standards that are supported by the National Committee for Quality Assurance (NCQA).

It is our objective to provide access to the highest quality of care for our members. As a validation of that objective, we often pursue accreditation by independent organizations that have been established to promote healthcare quality. The NCQA Health Plan Accreditation and URAC Health Plan Accreditation programs provide unbiased, third party reviews to verify and publicly report results on specific quality care metrics. While we have achieved or are pursuing accreditation for all of our plans, accreditation is only one measure of our ability to provide access to quality care for our members. We currently have NCQA health plan accreditation in 19 of 22 eligible states.

CMS developed the Medicare Advantage Star ratings system to help consumers choose among competing plans, awarding between 1.0 and 5.0 stars to Medicare Advantage plans based on performance in certain measures of quality. For the 2018 Star rating (calculated in 2017 for the quality bonus payment in 2019), our California D-SNP, Oregon HMO, Oregon PPO, and Arizona D-SNP contracts received 4.0 out of 5.0 Stars. The California HMO, Ohio, Texas, and Wisconsin D-SNPs, and Oregon Trillium HMO contracts were measured at 3.5 Stars, and our Arizona HMO and Florida D-SNP contracts received 3.0 Stars. In addition, for the 2018 Star rating, we carry a 3.5 Star parent organization rating. We are currently appealing the 2018 Star rating.

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SPECIALTY SERVICES

Our specialty services are a key component of our healthcare strategy and complement our core Managed Care business. Our provision of specialty services diversifies our revenue stream, enhances the quality of health outcomes for our members and others, and allows Centene to manage costs. Our Envolve brand brings together our extensive portfolio of specialty healthcare solutions. Envolve leverages our collective expertise in pharmacy solutions; health, triage, wellness and disease management; and vision and dental services, to provide integrated and comprehensive healthcare for members. Our specialty services are provided primarily as follows:

- Pharmacy Solutions. Envolve Pharmacy Solutions utilizes innovative, flexible solutions and customized care management. We offer traditional pharmacy benefits management as well as comprehensive specialized pharmacy benefit services through our specialty pharmacy, AcariaHealth. Our traditional pharmacy benefits management program offers progressive pharmacy benefits management services that are specifically designed to improve quality of care while containing costs. This is achieved through a low cost strategy that helps optimize clients' pharmacy benefits. Services that we provide include claims processing, pharmacy network management, benefit design consultation, drug utilization review, formulary and rebate management, online drug management tools, mail order pharmacy services, home delivery services, analytics and clinical consulting and patient and physician intervention. AcariaHealth offers specialized care management services for complex diseases and enhances the patient care offering through collaboration with providers and the capture of relevant data to measure patient outcomes.

- Health, Triage, Wellness, and Disease Management Services. Envolve PeopleCare brings together our behavioral health, nurse advice, telehealth, and health, wellness and disease guidance programs, allowing for a focus on individual health management through education and empowerment. Our life and health management programs specialize to encourage healthy behaviors, promote healthier workplaces, improve workforce and societal productivity and reduce healthcare costs. We offer telehealth services where members engage with customer service representatives and nursing staff who provide health education and triage advice and offer continuous access to health plan functions. Our staff can arrange for urgent pharmacy refills, transportation and qualified behavioral health professionals for crisis stabilization assessments.

- 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.

- Care Management Software. Casenet is a software provider of innovative care management solutions that automate the clinical, administrative and technical components of care management programs, which is used by our health plans and available for sale to third parties.

- Correctional Healthcare Services. Centurion, our joint venture subsidiary with MHM Services Inc., provides comprehensive healthcare services to individuals incarcerated in Florida, Massachusetts, Minnesota, Mississippi, New Mexico, Tennessee and Vermont state correctional facilities.

- Home-based Primary Care. U.S. Medical Management (USMM) provides home-based primary care services for high acuity populations and participates as an Accountable Care Organization (ACO) through the CMS Medicare Shared Savings Program.

- Integrated Long-Term Care. LifeShare provides home and community-based support for people with intellectual and developmental disabilities, children in the child welfare system and people of all ages and abilities, with a focus on

those that are often marginalized by society. In addition, LifeShare operates school-based programs that focus on students with special needs.

- Management Services. Envolve provides comprehensive management services for managed care organizations and partners with organizations to offer coordinated healthcare services and programs to their members.

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Federal Services. Health Net Federal Services (HNFS) has a Managed Support Contract in the West Region for the DoD TRICARE program. The services that are provided are structured as cost reimbursement arrangements for healthcare costs plus administrative fees received in the form of fixed prices, fixed unit prices, and contingent fees and payments based on various incentives and penalties. 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. HNFS also supports the PC3 program, which provides eligible veterans coordinated, timely access to care through a comprehensive network of non-VA providers who meet VA quality standards when a local VA medical center cannot readily provide the care. Additionally, our wholly owned subsidiary, MHN Government Services, is party to a MFLC contract that was awarded by the DoD to implement, administer and monitor the non-medical counseling MFLC program.

We currently have NCQA accreditation and URAC accreditation for several of our specialty companies.

CORPORATE COMPLIANCE

Our Ethics and Compliance program assists the organization in developing effective internal controls that promote prevention and detection of fraud, waste and abuse and resolution of instances of conduct that do not conform to federal and state law and private payor healthcare program requirements, as well as our own ethics and business policies. Responsibilities also include the ongoing maintenance of our privacy program and oversight of the Health Insurance Portability and Accountability Act (HIPAA) as they pertain 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 (OIG). Our program contains each of the seven elements suggested by the Sentencing Guidelines and the OIG guidance. 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 ethics and compliance, which is assessed periodically to measure the values and engagement of the organization. Our Corporate Compliance intranet site, accessible to all employees, contains our Business Ethics and Conduct Policy (Code of Conduct), Compliance Program description and resources for employees to report concerns or ask questions. If needed, employees have access to the contact information for our Board of Directors' Audit Committee Chairman to report concerns. 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 employees or other persons to report suspected incidents of misconduct, fraud, waste, abuse or other compliance violations anonymously. Furthermore, the Board of Directors has established a Corporate Compliance committee that, among other things, reviews ethics and compliance reports on a quarterly basis.

COMPETITION

We operate in a highly competitive environment in an industry subject to ongoing significant changes resulting from the ACA, business consolidations, new strategic alliances, market pressures, and regulatory and legislative reform including but 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.

In our business, our principal competitors for customers, members, and providers consist of the following types of organizations:

- Medicaid Managed Care Organizations that focus on providing healthcare services to Medicaid recipients. These organizations consist of national and regional organizations, as well as not-for-profits and smaller organizations that operate in one city or state and are owned by providers, primarily hospitals.

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- National and Regional Commercial Managed Care Organizations that have Medicaid and Medicare members in addition to members in private commercial plans. Some of these organizations offer a range of specialty services including pharmacy benefits management, behavioral health management, health management, and nurse triage call support centers.

- Primary Care Case Management Programs that are established by the states through contracts with primary care providers. Under these programs, physicians provide primary care services to Medicaid recipients, as well as limited medical management oversight.

- Accountable Care Organizations that consist of groups of doctors, hospitals, and other healthcare providers, who come together to give coordinated high quality care to their patients.

We compete with other managed care organizations and specialty companies for state, federal, and commercial contracts. In addition, the impact of the ACA and potential growth in our segment may attract new competitors including technology companies, new joint ventures, financial services firms, consulting firms and other non-traditional competitors. Before granting a contract, state and federal government agencies consider many factors. These factors include quality of care, financial condition, stability and resources and established or scalable infrastructure with a demonstrated ability to deliver services and establish adequate provider networks. Our specialty companies compete with other providers, such as disease management companies, individual health insurance companies, and pharmacy benefits managers for non-governmental contracts.

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, responsiveness to customer demands, financial stability, comprehensiveness of coverage, diversity of product offerings, market presence and reputation. The relative importance of each of these factors and the identity of our key competitors varies by market and product. We believe that we compete effectively against other healthcare industry participants.

We also compete with other managed care organizations in establishing provider networks. When contracting with various health plans, we believe that providers consider existing and potential member volume, reimbursement rates, medical management 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.

REGULATION

Our operations are comprehensively regulated at 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 regulations, requiring governance practices and risk and solvency assessment reporting. States have adopted these or similar measures to enhance regulations relating to corporate governance and internal controls of HMOs and insurance companies. We are required to maintain a risk management framework and file reports with state insurance regulators.

Regulatory agencies generally have substantial discretion to issue regulations and 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 or national levels. For example, the current administration and certain members of Congress have indicated that they may continue to pursue significant amendments to the ACA. Even if the ACA is not amended or repealed, the current administration could propose changes impacting implementation of the ACA. The ultimate content and timing of any legislation enacted under the current administration that would affect the ACA remains uncertain.

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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 significant fees, assessments and taxes, including the non-deductible tax (technically called a "fee") on health insurers based on prior year net premiums written (the "health insurer fee" or "HIF"); 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 the 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 implementation of the ACA, as well as the potential repeal of, or changes to, the ACA, see the risk factor below entitled “The implementation of Health Reform Legislation, as well as potential repeal of or changes to Health Reform Legislation, could materially and adversely affect our results of operations, financial position and cash flows.”

Our regulated subsidiaries are licensed to operate as health maintenance organizations (HMOs), preferred provider organizations (PPOs), third party administrators, 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 insurance, health and/or human services departments, departments of insurance, boards of pharmacy and other healthcare providers, and departments of health that oversee the activities of managed care organizations and health plans providing or arranging to provide services to enrollees.

The process for obtaining authorization to operate as a managed care organization, health insurance plan, pharmacy or provider organizations 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, and an adequate provider network and procedures for covering emergency medical conditions. For example, under both state managed care organization 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 managed care organization 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 regulations that may affect our business and results of operations. These 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;
- disclosure requirements regarding provider fee schedules and coding procedures; and
- programs to monitor and supervise the activities and financial solvency of provider groups.

Federal law has also implemented other health programs that are partially funded by the federal government, such as the Medicaid program. 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.

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 capital structure, ownership, financial condition, intercompany transactions and general business operations. In addition, depending on the size and nature of the transaction, there are various notice and reporting requirements that 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.

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Additionally, the holding company acts 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, which 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 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 regulation also varies by state and covers all or most of the subject area 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. In many of the states where our pharmacies deliver pharmaceuticals, there are laws and regulations that require out-of-state mail order pharmacies to register with that state’s board of pharmacy or similar regulatory body. These states generally permit the pharmacy to follow the laws of the state in which the mail order pharmacy is located, although some states require that we also comply with certain laws in that state.

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 cannot be excluded from participation at both the state and federal levels. Our facilities are periodically reviewed by state departments of health and other regulatory agencies to ensure the environment is safe to provide care.

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. 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 also 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 Contracts

In addition to being a licensed insurance company or HMO, in order to be a Medicaid managed care organization 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 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 special needs plans, which are regulated by CMS, for dual eligible individuals within the state. We also contract with states to provide healthcare services to

correctional facilities.

We provide Medicare Advantage, Dual Eligible Special Needs Plans (D-SNPs), and Medicare-Medicaid Plans (MMP) 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. We additionally provide behavioral and other healthcare services to correctional systems under contracts in certain states which are also subject to state regulation.

Our government contracts include government-sponsored managed care and administrative services contracts through the TRICARE program, the Department of Defense Military and Family Life Counseling program, the U.S. Department of Veterans Affairs Patient Centered Community Care program and certain other healthcare-related government contracts.

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Our state and federal contracts and the regulatory provisions applicable to us generally set forth the requirements for operating in the Medicaid and Medicare sectors, 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
- organization and administrative systems

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

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

Marketplace Contracts

We operate in 15 states under federally-facilitated and state-based Marketplace contracts with CMS that expire annually. In 2018, we began operating under Marketplace contracts in Kansas, Missouri and Nevada. We expect to begin operating under a Marketplace contract in New York, pending the closing of the Fidelis Care Transaction.

We operate under a contract 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 "Arkansas Works"). We also operate under a contract with the New Hampshire Department of Health and Human Services to participate in the Medicaid expansion model that New Hampshire has adopted (referred to as the “Premium Assistance Program”).

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, the Health Insurance

Portability and Accountability Act (HIPAA), the Federal Trade Commission Act, the Gramm-Leach-Bliley Financial Modernization Act of 1999 (Gramm-Leach-Bliley Act), 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.

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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 Generals 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 (GINA) which clarified that genetic information is protected under HIPAA and prohibits most health plans from using or disclosing genetic information for underwriting purposes. This Omnibus rule enhances the privacy protections and strengthens the government's ability to enforce the law. 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 transaction standards were modified on October 1, 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 (PCI) 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.

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 entities. The focus of these efforts has been directed at Medicare, Medicaid, Health Insurance Marketplace and commercial products. The 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 false claim act statutes that closely resemble the federal False Claims Act. The laws and regulations relating to fraud, waste and abuse and the requirements applicable to health plans 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 waste, fraud 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.

EMPLOYEES

As of December 31, 2017, we had approximately 33,700 employees. None of our employees are represented by a union. We believe our relationships with our employees are positive.

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EXECUTIVE OFFICERS OF THE REGISTRANT

The following table sets forth information regarding our executive officers, including their ages, at February 16, 2018:

Name	Age	Position
Michael F. Neidorff	75	Chairman and Chief Executive Officer
Christopher D. Bowers	62	Executive Vice President, Markets
Cynthia J. Brinkley	58	President and Chief Operating Officer
Mark J. Brooks	48	Executive Vice President and Chief Information Officer
Jesse N. Hunter	42	Executive Vice President and Chief Strategy Officer
Christopher R. Isaak	51	Senior Vice President, Corporate Controller and Chief Accounting Officer
Jeffrey A. Schwaneke	42	Executive Vice President, Chief Financial Officer and Treasurer
Keith H. Williamson	65	Executive Vice President, General Counsel and Secretary

Michael F. Neidorff. Mr. Neidorff has served as our Chairman and Chief Executive Officer since November 2017. From May 2004 to November 2017, he served as Chairman, President and Chief Executive Officer. From May 1996 to May 2004, he served as President, Chief Executive Officer and as a member of our Board of Directors.

Christopher D. Bowers. Mr. Bowers has served as our Executive Vice President of Markets since November 2016. From March 2007 to November 2016, he served as our Senior Vice President of Health Plans.

Cynthia J. Brinkley. Ms. Brinkley has served as our President and Chief Operating Officer since November 2017. From January 2016 to November 2017, she served as Executive Vice President, Global Corporate Development. From November 2014 to January 2016, she served as Executive Vice President, International Operations and Business Integration. Prior to joining Centene, she served as Vice President of Global Human Resources at General Motors from 2011 to 2013.

Mark J. Brooks. Mr. Brooks has served as our Executive Vice President and Chief Information Officer since November 2017. From April 2016 to November 2017, he served as Senior Vice President and Chief Information Officer. Prior to joining Centene, he served as the Chief Information Officer at Health Net from 2012 to 2016.

Jesse N. Hunter. Mr. Hunter has served as our Executive Vice President and Chief Strategy Officer since November 2017. From January 2016 to November 2017, he served as Executive Vice President, Products. From December 2012 to January 2016, he served as Executive Vice President, Chief Business Development Officer. From February 2012 to December 2012, he served as our Executive Vice President, Operations.

Christopher R. Isaak. Mr. Isaak has served as our Senior Vice President, Corporate Controller and Chief Accounting Officer since April 2016. Prior to joining Centene, he served as Vice President, Corporate Controller at TTM Technologies from 2015 to 2016 and Vice President, Corporate Controller at Viasystems Group, Inc. from 2006 to 2015 and served as Chief Accounting Officer from 2010 to 2015.

Jeffrey A. Schwaneke. Mr. Schwaneke has served as our Executive Vice President, Chief Financial Officer and Treasurer since March 2016. From July 2008 to March 2016, he served as our Senior Vice President, Corporate Controller and served as our Chief Accounting Officer from September 2008 to March 2016.

Keith H. Williamson. Mr. Williamson has served as our Executive Vice President, General Counsel and Secretary since November 2012.

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, or SEC. We make these filings available on our website free of charge, the URL of which is http://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 (http://www.sec.gov) that contains our annual, quarterly and current reports and other information we file electronically with the SEC. You can read and copy any materials we file with the SEC at the SEC's Public Reference Room at 100 F Street, N.E., Room 1850, Washington, D.C. 20549. You may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. Information on our website does not constitute part of this Annual Report on Form 10-K.

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ITEM 1A. Risk Factors

FACTORS THAT MAY AFFECT FUTURE RESULTS AND THE TRADING PRICE OF OUR COMMON STOCK

You should carefully consider the risks described below before making an investment decision. The trading price of our common stock could decline 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. Unless the context otherwise requires, the terms the “Company,” “we,” “us,” “our” or similar terms and “Centene” (i) prior to the closing of the Proposed Fidelis Acquisition, refer to Centene Corporation, together with its consolidated subsidiaries, without giving effect to the Proposed Fidelis Acquisition, and (ii) upon and after the closing of the Proposed Fidelis Acquisition, refer to us, after giving effect to the Proposed Fidelis Acquisition.

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 substantially affect our financial position, results of operations and cash flows.

The majority of our revenues come from government subsidized healthcare programs including Medicaid, Medicare, TRICARE, VA, CHIP, LTSS, ABD, Foster Care and Health Insurance Marketplace premiums. Under most 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 the states have shared the costs for this program, with the federal share currently averaging around 57%. We are therefore exposed to risks associated with U.S. 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 government to terminate contracts with it, 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; and 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. 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, VA, CHIP, LTSS, ABD and Foster Care. 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. 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 continue to 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 the contract for the convenience of the government, may materially and adversely affect our results of operations, financial position and cash flows. In addition, if a federal government shutdown were to occur for a prolonged period

of time, federal government payment obligations, including its obligations under Medicaid, Medicare, TRICARE, VA, CHIP, LTSS, ABD, Foster Care and the Health Insurance Marketplaces, 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 position, 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 position, 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.

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Finally, changes in these programs could reduce the number of persons enrolled in or eligible for these programs or increase our administrative or healthcare costs under these programs. For example, maintaining current eligibility levels could cause states to reduce reimbursement or reduce benefits in order for states to afford to maintain 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 position and cash flows.

Our Medicare programs are subject to a variety of 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 or penalties; if we do not submit adequate bids in our existing markets or any expansion markets; if our existing contracts are 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 financial performance. As previously announced, CMS recently published Medicare Star ratings for the 2018 rating year. The achievement of Star ratings of four or higher for the 2018 rating year qualifies Medicare Advantage plans for quality bonus payments in 2019. The results from CMS indicate that Health Net of California, Inc.'s Medicare Advantage plan (H0562) will move to a 3.5 Star rating from a 4.0 Star rating for the 2018 rating year. The effect of this Star rating change will lower our parent Star rating for the 2018 rating year from 4.0 stars to 3.5 stars and, therefore, our plans that use the parent rating as well as the Medicare Advantage plan (H0562) will not be eligible for the quality bonus payments in 2019. These lowered Star ratings for the 2018 rating year for the Medicare Advantage plan (H0562) and the Company may reduce the attractiveness of the affected plans and our other offerings to members, reduce revenue from the affected plan and impact our Medicare expansion efforts, which are a strategic focus for the Company. We continue to evaluate the potential impact of the lowered ratings on our revenues and expansion efforts in 2019. 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.

Failure to accurately estimate and price our medical expenses or effectively manage our medical costs or related administrative costs could negatively affect our financial position, results of operations and cash flows.

Our profitability, to a significant degree, depends on our ability to 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 Medicaid revenue is often based on bids submitted before the start of the initial contract year. If our actual medical expense exceeds 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, hospital and pharmaceutical costs, disasters, the potential effects of climate change, major epidemics, pandemics or newly emergent viruses, new medical technologies, new pharmaceutical compounds, increases in provider fraud and other external factors, including general economic conditions such as 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. In addition, the 2018 marketplace for individual products may continue to be less stable than in previous years because, among other things, other health plans have changed or stopped offering their

Health Insurance Marketplace products in the states we expect to serve in 2018 or have announced plans to change their Health Insurance Marketplace product offerings in 2018. Also, member behavior could be influenced by the repeal of the ACA's individual mandate in the Tax Cuts and Jobs Act of 2017 (TCJA), and further uncertainty surrounding other potential changes to the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act, collectively referred to as Affordable Care Act (ACA).

Our medical expense includes claims reported but not paid, estimates for claims incurred but not reported, and estimates for the costs necessary to process unpaid claims at the end of each period. Our development of the medical claims liability estimate is a continuous process which 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 expense in the period in which the changes are identified. Given the uncertainties inherent in such estimates, there can be no assurance that our medical claims liability estimate will be adequate, and any adjustments to the estimate may unfavorably impact our results of operations and may be material.

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Additionally, when we commence operations in a new state, region or 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 position could be 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.

The implementation of the ACA, as well as potential repeal of or changes to the ACA, could materially and adversely affect our results of operations, financial position and cash flows.

In March 2010, the ACA was enacted. While the constitutionality of the ACA was generally upheld by the Supreme Court in 2012, the Court determined that states could elect to opt out of the Medicaid expansion portion of ACA without losing all federal money for their existing Medicaid programs.

Under the ACA, Medicaid coverage was expanded to all individuals under age 65 with incomes up to 138% of the federal poverty level beginning January 1, 2014, subject to each states' election. The federal government pays the entire costs for Medicaid coverage for newly eligible beneficiaries for three years (2014 through 2016). Beginning in 2017, the federal share begins to decline, ending at 90% for 2020 and subsequent years. As of December 31, 2017, 32 states and the District of Columbia have expanded Medicaid eligibility, and additional states continue to discuss expansion. The ACA also maintained CHIP eligibility standards through September 2019.

The ACA required the establishment of Health Insurance Marketplaces for individuals and small employers to purchase health insurance coverage. The ACA also required insurers participating on the Health Insurance Marketplaces to offer a minimum level of benefits and included guidelines on setting premium rates and coverage limitations. On December 22, 2017, the TCJA was signed, repealing the individual mandate requirement of the ACA beginning in 2019. This change and other potential changes involving the functioning of the Health Insurance Marketplaces as a result of new legislation, regulation or executive action, could impact our business and results of operations.

Any failure to adequately price products offered or reduction in products offered in the Health Insurance Marketplaces may have a negative impact on our results of operations, financial position and cash flow. Among other things, due to the repeal of the individual mandate in the TCJA, we may be adversely selected by individuals who have higher acuity levels than those individuals who selected us in the past and healthy individuals may decide to opt out of the pool altogether. In addition, the risk corridor, reinsurance and risk adjustment ("three Rs") provisions of the ACA established to apportion risk amongst insurers may not be effective in appropriately mitigating the financial risks related to the Marketplace product. Further, the three Rs may not be adequately funded. Moreover, changes in the competitive marketplace over time may exacerbate the uncertainty in these relatively new markets. For example, competitors seeking to gain a foothold in the changing market may introduce pricing 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, require us to increase premium rates or result in funding issues under the three Rs. These potential exits and other continued volatility in this market may be further exacerbated by the conclusion of the risk corridor and reinsurance programs as of January 1, 2017. Our continued success in the exchanges is dependent on our ability to successfully respond to these changes in the market over time. Any significant variation from our expectations regarding acuity, enrollment

levels, adverse selection, the three Rs, or other assumptions utilized in setting adequate premium rates could have a material adverse effect on our results of operations, financial position and cash flows.

The U.S. Department of Health and Human Services (HHS) has stated that it will consider a limited number of premium assistance demonstration proposals from States that want to privatize Medicaid expansion. States must provide a choice between at least two qualified health plans and offer very similar benefits as those available in the Health Insurance Marketplaces. Arkansas became the first state to obtain federal approval to use Medicaid funding to purchase private insurance for low-income residents and we began operations under the program beginning January 1, 2014. As of December 31, 2017, seven states had approved Section 1115 waivers to implement the ACA's Medicaid expansion in ways that extend beyond the flexibility provided by the federal law.

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The ACA imposed an annual insurance industry assessment of $8.0 billion in 2014, and $11.3 billion in each of 2015 and 2016, with increasing annual amounts thereafter. The health insurer fee payable in 2017 was suspended by the Consolidated Appropriations Act for fiscal year 2016. However, the $14.3 billion payment resumes in 2018 for the fiscal year 2017. Such assessments are not deductible for federal and most state income tax purposes. The fee is allocated based on health insurers' premium revenues in the previous year. Each health insurer's fee is calculated by multiplying its market share by the annual fee. Market share is based on commercial, Medicare, and Medicaid premium revenues. Not-for-profit insurers may have a competitive advantage since they are exempt from paying the fee if they receive at least 80% of their premium revenues from Medicare, Medicaid, and CHIP, and other not-for-profit insurers are allowed to exclude 50% of their premium revenues from the fee calculation. If we are not reimbursed by the states for the cost of the federal premium assessment (including the associated tax impact), or if we are unable to otherwise adjust our business model to address this new assessment, our results of operations, financial position and cash flows may be materially adversely affected.

There are numerous steps regulators required for continued implementation of the ACA, including the promulgation of a substantial number of new and potentially more onerous federal regulations. For example, in April 2016, CMS issued final regulations that revised existing Medicaid managed care rules by establishing a minimum MLR standard for Medicaid of 85% and strengthening provisions related to network adequacy and access to care, enrollment and disenrollment protections, beneficiary support information, continued service during beneficiary appeals, and delivery system and payment reform initiatives, among others. 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.

In addition, House v. Hargan (previously v. Burwell, et al., and v. Price, et al.), the suit that was brought by House Republicans, was settled in December 2017. The new administration's decision to stop the cost sharing subsidies rendered further challenge to the cost sharing subsidy payments unnecessary. While 2018 premium rates for Health Insurance Marketplace were set without factoring in the cost sharing subsidy payments from the federal government, the new administration's decision to end payments could affect our earnings.

Changes to, or repeal of, portions or the entirety of the ACA, could materially and adversely affect our business and financial position, results of operations or cash flows. Even if the ACA is not amended or repealed, the new administration could propose changes impacting implementation of the ACA, which could materially and adversely affect our financial position or operations. However, the ultimate content, timing or effect of any potential future legislation enacted under the new administration cannot be predicted.

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 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 managed care organizations providing or arranging to provide services to Medicaid, Medicare, Health Insurance Marketplace enrollees or other beneficiaries. For example, 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.

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; 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, federal or country level 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 and local 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.

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Our contracts with states may require us to maintain a minimum HBR or may require us to share profits in excess of certain levels. In certain circumstances, our plans may be required to return premium back to the state in the event profits exceed established levels or HBR does not meet the minimum requirement. Other states may require us to meet certain performance and quality metrics in order to maintain our contract 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. 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. 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 not allow us to continue to participate in their government programs, or we may fail to win procurements to participate in such programs which could materially and adversely affect our results of operations, financial position 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 Foreign Corrupt Practices Act. Our 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 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 businesses providing pharmacy benefit management (PBM) and specialty pharmacy services face regulatory and other risks and uncertainties which could materially and adversely affect our results of operations, financial position and cash flows.

We provide PBM and specialty pharmacy services, including through our Envolve Pharmacy Solutions product. These businesses are subject to federal and state laws that govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. We also conduct business as a mail order pharmacy and specialty pharmacy, which subjects these businesses to extensive federal, state and local laws and regulations. In addition, federal and state legislatures 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 PBM and specialty pharmacy businesses would be materially and adversely affected by an inability to contract on favorable terms with pharmaceutical manufacturers and other suppliers, including with respect to the pricing of new specialty and generic drugs. In addition, our PBM and specialty pharmacy businesses could face potential claims in connection with purported errors by our mail order or specialty pharmacies, including in connection with the risks inherent in the authorization, compounding, packaging and distribution of pharmaceuticals and other healthcare products. Disruptions at any of our mail order or 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 position and cash flows.

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If any of our government contracts are terminated or are not renewed on favorable terms or at all, 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 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. When our contracts with the government expire, they may be opened for bidding by competing healthcare providers, and there is no guarantee that our contracts will be renewed or extended. Competitors may buy their way into the market by submitting bids with lower pricing. 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 eligibility, enrollment and dis-enrollment processes for covered services, eligible providers, periodic financial and informational reporting, quality assurance, timeliness of claims payment and agreement to maintain a Medicare plan in the state and financial standards, among other things, and are subject to cancellation if we fail to perform in accordance with the standards set by regulatory agencies.

We are also subject to various reviews, audits and investigations to verify our compliance with the terms of our contracts with various governmental agencies, as well as compliance with applicable laws and regulations. Any 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 of one or more of our licenses; lowered quality Star ratings; or require changes to the way we do business. In addition, under government procurement regulations and practices, a negative determination resulting from a government audit of our business practices could result in a contractor being fined, debarred and/or suspended from being able to bid on, or be awarded, new government contracts for a period of time.

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

We contract with independent third party vendors 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 and investigations and other adverse effects.

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 new programs to determine eligibility, new processes to assign or enroll eligible members into health plans, or chooses new subcontractors, there is an increased potential for an unanticipated impact on the overall number of members assigned to managed care plans.

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 a negative adverse effect on our results of operations, liquidity and financial condition.

Execution of our growth strategy may increase costs or liabilities, or create disruptions in our business.

Our growth strategy includes, without limitation, the acquisition and expansion of health plans participating in government sponsored healthcare programs and specialty services businesses, 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, or an acquisition may not perform as well as expected or may not achieve timely profitability. We also face the risk that we will not be able to effectively integrate acquisitions into our existing operations effectively without substantial expense, delay or other operational or financial problems and we may need to divert more management resources to integration than we planned.

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In connection with start-up operations and system migrations, we may incur significant expenses prior to commencement of operations and the receipt of revenue. For example, in order to obtain a certificate of authority in most jurisdictions, we must first establish a provider network, have systems in place and demonstrate our ability to administer a state contract and process claims. We may experience delays in operational start dates. As a result of these factors, start-up operations may decrease our profitability. In addition, we are planning to expand our business internationally and we will be subject to additional risks, including, but not limited to, political risk, an unfamiliar regulatory regime, currency exchange risk and exchange controls, cultural and language differences, foreign tax issues, and different labor laws and practices.

If we are unable to effectively execute our growth strategy, our future growth will suffer and our results of operations could be harmed.

If competing managed care programs are unwilling to purchase specialty services from us, we may not be able to successfully implement our strategy of diversifying our business lines.

We are seeking to diversify our business lines into areas that complement our government sponsored health plan business in order to grow our revenue stream and balance our dependence on risk reimbursement. In order to diversify our business, we must succeed in selling the services of our specialty subsidiaries not only to our managed care plans, but to programs operated by third-parties. Some of these third-party programs may compete with us in some markets, and they therefore may be unwilling to purchase specialty services from us. In any event, the offering of these services will require marketing activities that differ significantly from the manner in which we seek to increase revenues from our government sponsored programs. Our ineffectiveness in marketing specialty services to third-parties may impair our ability to execute our business strategy.

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 extreme 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 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 a 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.

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. These subsidiaries are subject to 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 our subsidiaries' request to pay dividends, the funds available to us

would be limited, which could harm our ability to implement our business strategy.

We derive a majority of our premium revenues from operations in a limited number of states, and our financial position, results of operations or cash flows would be materially affected by a decrease in premium revenues or profitability in any one of those states.

Operations in a limited number of states have accounted for most 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. 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, economic conditions and similar factors in those states. For example, states we currently serve may open the bidding for their Medicaid program to other health insurers through a request for proposal process. Our inability to continue to operate in any of the states in which we operate could harm our business.

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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, 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 technology companies, new joint ventures, financial services firms, consulting firms and 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 has occurred 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.

If we are unable to maintain relationships with our provider networks, our profitability may be harmed.

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 services, maintain financial solvency or avoid disputes with other providers. 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 position 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, resulting in a reduction in the competitive environment. In addition, if these providers refuse to contract with us, use their market position to negotiate contracts 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 harmed. 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. HNL expects to vigorously defend its claims payment practices. Nevertheless, 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.

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

We are highly dependent on our ability to attract and retain qualified personnel to operate and expand our business. We would 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 or other key employees may be difficult and may take an extended period of time because of the limited number of individuals in the managed care and specialty services 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. If we are unable to attract, retain and effectively manage the succession plans for key personnel, executives and senior management, our business and financial position, results of operations or cash flows could be harmed.

If we are unable to integrate and manage our information systems effectively, our operations could be disrupted.

Our operations depend significantly on effective information systems. The information gathered and processed by our information systems 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 for membership verifications, claims status and other information. Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs and regulatory requirements. We regularly upgrade and expand our information systems' capabilities. If we experience difficulties with the transition to or from information systems or do not appropriately integrate, maintain, enhance or expand our information systems, we could suffer, among other things, operational disruptions, loss of existing members and difficulty in attracting new members, regulatory problems and increases in administrative expenses. In addition, our ability to integrate and manage our information systems may be impaired as the result of events outside our control, including acts of nature, such as earthquakes or fires, or acts of terrorists.

From time to time, we may become involved in costly and time-consuming litigation and other regulatory proceedings, which require significant attention from our management.

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 alleging failure to pay for or provide healthcare, claims related to non-payment or insufficient payments for out-of-network services, claims alleging bad faith, investigations regarding our submission of risk adjuster claims, putative securities class actions, and claims related to the imposition of new taxes, including but not limited to claims that may have retroactive application. Due to the inherent uncertainties of litigation and regulatory proceedings, we cannot accurately predict the ultimate outcome of any such proceedings. An unfavorable outcome could have a material adverse impact on our business and financial position, results of operations and/or cash flows and may affect our reputation. 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 harm our business and financial position, results of operations or cash flows.

An impairment charge with respect to our recorded goodwill and intangible assets could have a material impact on our results of operations.

We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. Changes in business strategy,

government regulations or economic or market conditions have resulted and may result in impairments of our goodwill and other intangible assets at any time in the future. Our judgments regarding the existence of impairment indicators are based on, among other things, legal factors, market conditions, and operational performance. For example, the non-renewal of our health plan contracts with the state in which they operate may be an indicator of impairment. 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 in the period in which the impairment occurs.

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

As part of our normal operations, we collect, process and retain confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 and the Gramm-Leach-Bliley Act, which require us to protect the privacy of medical records and safeguard personal health information we maintain and use. 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. Despite our best attempts to maintain adherence to information privacy and security best practices as well as compliance with applicable laws, rules and contractual requirements, our facilities and systems, and those of our third party service providers, may be vulnerable to privacy or security breaches, acts of vandalism or theft, malware or other forms of cyber-attack, misplaced or lost data including paper or electronic media, programming and/or human errors or other similar events. 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. However, future data breaches could require us to expend significant resources to remediate any damage, interrupt our operations and damage our reputation, subject us to state or federal agency review and could also result in enforcement actions, material fines and penalties, litigation or other actions which could have a material adverse effect on our business, reputation and results of operations, financial position and cash flows.

In addition, HIPAA broadened the scope of fraud and abuse laws applicable to healthcare companies. HIPAA established new enforcement mechanisms to combat fraud 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 penalties and to create a private right of action under HIPAA, which could entitle patients to seek monetary damages for violations of the privacy rules. Additionally, HHS continued its auditing program in 2016 to assess compliance efforts by covered entities and business associates. Through a second phase of audits, which commenced for covered entities in July 2016, HHS focused on a review of policies and procedures adopted and employed by covered entities and their business associates to meet selected standards and implementation specifications of the HIPAA Privacy, Security, and Breach Notification Rules. An audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

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

We, along with all other companies involved in public healthcare programs are the subject of fraud and abuse investigations from time to time. The regulations and contractual requirements applicable to participants in these public sector programs are complex and subject to change. Violations of fraud 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, VA and other federal healthcare programs and federally funded state health programs. Fraud 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 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 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. Federal and state governments have made investigating and prosecuting healthcare fraud and abuse a priority. In the event we fail to comply with the extensive federal and state fraud and abuse laws, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

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A failure in or breach of our operational or security systems or infrastructure, or those of third parties with which we do business, including as a result of cyber-attacks, could have an adverse effect on our business.

Information 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 state agents. Our operations rely on the secure processing, transmission and storage of confidential, proprietary and other information in our computer systems and networks.

Security breaches may arise from external or internal threats. External breaches include hacking personal information for financial gain, attempting to cause harm or interruption to our operations, or intending to obtain competitive information. We experience attempted external hacking or malicious attacks on a regular basis. We maintain a rigorous system of preventive and detective 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. Internal breaches may result from inappropriate security access to confidential information by rogue employees, consultants or third party service providers. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, financial data, competitively sensitive information, or other proprietary data, whether by us or a third party, could have a material adverse effect on our business reputation, financial condition, cash flows, or results of operations.

The market price of our common stock may decline as a result of significant acquisitions.

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 acquisitions if, among other things, we are unable to achieve the expected growth in earnings, or if the operational cost savings estimates in connection with the integration of acquired businesses with ours are not realized, or if the transaction costs related to the acquisitions and integrations are greater than expected. The market price also may decline if we do not achieve the perceived benefits of the acquisitions as rapidly or to the extent anticipated by financial or industry analysts or if the effect of the acquisitions on our financial position, 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 business with Health Net and realize the anticipated benefits of the acquisition.

We completed the acquisition of Health Net on March 24, 2016. The success of the acquisition of Health Net will depend, in part, on our ability to successfully combine the businesses of the Company and Health Net and realize the anticipated benefits, including synergies, cost savings, growth in earnings, innovation and operational efficiencies, from the combination. 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 be harmed.

The integration of Health Net's business with our existing business is a complex, costly and time-consuming process. We have not previously completed a transaction comparable in size or scope to the acquisition of Health Net. The integration of the two companies 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 combined company;
- maintaining employee morale and retaining key management and other employees;
- 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 changes with respect to government healthcare programs, the ACA and any regulations enacted thereunder; and
- unforeseen expenses or delays associated with the acquisition and/or integration.

Many of these factors will be outside of our control and any one of them could result in delays, increased costs, decreases in the amount of expected revenues and diversion of management's time and energy, which could materially affect our financial position, results of operations and cash flows.

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We have incurred substantial expenses related to the completion of the acquisition of Health Net and are incurring substantial expenses related to the integration of Health Net.

We are in the process of integrating a large number of processes, policies, procedures, operations, technologies and systems, including sales, pricing, and marketing, among other things. In addition, the businesses of Centene and Health Net will continue to maintain a presence in St. Louis, Missouri and Woodland Hills, California, respectively. The substantial majority of these costs will be non-recurring expenses related to the acquisition (including financing of the acquisition), facilities and systems consolidation costs. We may incur additional costs to maintain employee morale and to retain key employees. We are also incurring transaction fees and costs related to formulating integration plans for the combined business, and the execution of these plans may lead to additional unanticipated costs. These incremental transaction and acquisition related costs may exceed the savings we expect to achieve from the elimination of duplicative costs and the realization of other efficiencies related to the integration of the businesses, particularly in the near term and in the event there are material unanticipated costs.

Our future results may be adversely impacted if we do not effectively manage our expanded operations following the completion of our acquisition of Health Net.

The size of our business following the acquisition of Health Net is significantly larger than the size of either our or Health Net's respective businesses prior to the acquisition. Our ability to successfully manage the expanded business 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. We will also have to manage our expanded operations in compliance with certain undertakings with regulators that were agreed to in connection with the approval of the acquisition. These undertakings require significant investments by us, may restrict or impose additional material costs on our future operations and strategic initiatives in certain geographies, and subject us to various enforcement mechanisms. There can be no assurances that we will be successful in managing our expanded operations or that we will realize the expected growth in earnings, operating efficiencies, cost savings and other benefits.

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, 2017, we had consolidated indebtedness of approximately $4,699 million. We may further increase our indebtedness in the future. This increased indebtedness and higher debt-to-equity ratio will have the effect, among other things, of reducing our flexibility to respond to changing business and economic conditions and increasing borrowing costs.

Among other things, our revolving credit facility requires us to comply with various covenants that impose restrictions on our operations, including our ability to incur additional indebtedness, create liens, pay dividends, make investments or other restricted payments, sell or otherwise dispose of substantially all of our assets and engage in other activities. Our revolving credit facility also requires us to comply with a maximum leverage 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 the revolving 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.

The Proposed Fidelis Acquisition may not occur, and if it does, it may not be accretive and may cause dilution to our earnings per share, which may negatively affect the market price of our common stock.

Although we currently anticipate that the Proposed Fidelis Acquisition will occur and will be accretive to earnings per share (on an adjusted earnings basis that is not pursuant to GAAP) from and after the Proposed Fidelis Acquisition, this expectation is based on assumptions about our and Fidelis Care's business and preliminary estimates, which may change materially. As a result, should the Proposed Fidelis Acquisition occur, certain other amounts to be paid in connection with the Proposed Fidelis Acquisition may cause dilution to our earnings per share or decrease or delay the expected accretive effect of the Proposed Fidelis Acquisition and cause a decrease in the market price of our common stock. The Proposed Fidelis Acquisition may not occur as a result. In addition, we could also encounter additional transaction-related costs or other factors such as the failure to realize all of the benefits anticipated in the Proposed Fidelis Acquisition, including cost and revenue synergies. All of these factors could cause dilution to our earnings per share or decrease or delay the expected accretive effect of the Proposed Fidelis Acquisition and cause a decrease in the market price of our common stock.

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The Proposed Fidelis Acquisition is subject to conditions, some or all of which may not be satisfied, or completed on a timely basis, if at all. Failure to complete the Proposed Fidelis Acquisition could have material adverse effects on our business.

The completion of the Proposed Fidelis Acquisition is subject to a number of conditions, including, among others, the receipt of certain regulatory approvals, which make the completion and timing of the completion of the Proposed Fidelis Acquisition uncertain. Also, either we or Fidelis Care may terminate the asset purchase agreement if the Proposed Fidelis Acquisition has not been consummated by July 1, 2018 (or September 1, 2018 if the extension is exercised), except that this right to terminate the asset purchase agreement will not be available to any party whose failure to fulfill any obligation under the asset purchase agreement has been the cause of or resulted in the failure of the Proposed Fidelis Acquisition to be consummated on or before that date.

If the Proposed Fidelis Acquisition is not completed, our ongoing business may be materially adversely affected and, without realizing any of the benefits that we could have realized had the Proposed Fidelis Acquisition been completed, we will be subject to a number of risks, including the following: