UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2021

or

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

For the transition period from _____ to_____

Commission file number: 001-01011

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CVS HEALTH CORPORATION

(Exact name of registrant as specified in its charter)

Delaware		
(State or other jurisdiction of incorporation or organization)		(I.R
One CVS Drive,	**Woonsocket,**	**Rhode Island**
(Address of principal executive offices)		

Registrant's telephone number, including area code: **(401**

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

Title of each class	Trading Symbol(s)	Name of each excha registere
Common Stock, par value $0.01 per share	CVS	New York Stock

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of Act.

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Sect the Act.

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Sectio of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period registrant was required to file such reports), and (2) has been subject to such filing requirements fo days.

Indicate by check mark whether the registrant has submitted electronically every Interactive Data F be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the precedi (or for such shorter period that the registrant was required to submit such files).

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non filer, a smaller reporting company, or an emerging growth company. See the definitions of "large a filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 1 Exchange Act.

Large accelerated filer	☒	
Non-accelerated filer	☐	S
		E

If an emerging growth company, indicate by check mark if the registrant has elected not to use the for complying with any new or revised financial accounting standards provided pursuant to Section Act.

Indicate by check mark whether the registrant has filed a report on and attestation to its manageme effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-O 7262(b)) by the registered public accounting firm that prepared or issued its audit report.

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the A

The aggregate market value of the registrant's common stock held by non-affiliates was approximately $109,651,334,285 as of June 30, 2021, based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be affiliates of the registrant.

As of February 2, 2022, the registrant had 1,312,510,426 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The following materials are incorporated by reference into this Form 10-K:

Information contained in the definitive proxy statement for CVS Health Corporation's 2022 Annual Meeting of Stockholders, to be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year ended December 31, 2021 (the "Proxy Statement"), is incorporated by reference in Parts III and IV to the extent described therein.

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Unless the context otherwise requires, references to the terms "we," "our" or "us" used throughout this Annual Report on Form 10-K (this "10-K") refer to CVS Health Corporation (a Delaware corporation), together with its subsidiaries (collectively, "CVS Health" or the "Company"). References to competitors and other companies throughout this 10-K, including the information incorporated herein by reference, are for illustrative or comparison purposes only and are not identifying that these companies are the only competitors or closest competitors of the Company or any of the Company's businesses, products, or services.

CAUTIONARY STATEMENT CONCERNING FORWARD-LOOKING STATEMENTS

The Private Securities Litigation Reform Act of 1995 (the "Reform Act") provides a "safe harbor" for forward-looking statements, so long as (1) those statements are identified as forward-looking, and (2) the statements are accompanied by meaningful cautionary statements that identify important factors that could cause actual results to differ materially from those discussed in the statement. We are taking advantage of these safe harbor provisions.

Certain information contained in this 10-K is forward-looking within the meaning of the Reform Act or SEC rules. This information includes, but is not limited to: "Outlook for 2022" of Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A") included in Item 7, "Quantitative and Qualitative Disclosures About Market Risk" included in Item 7A, "Government Regulation" included in Item 1, and "Risk Factors" included in Item 1A. In addition, throughout this 10-K and our other reports and communications, we use the following words or variations or negatives of these words and similar expressions when we intend to identify forward-looking statements:

· Anticipates	*· Believes*	*· Can*	*· Continue*	*· Could*
· Estimates	*· Evaluate*	*· Expects*	*· Explore*	*· Forecast*
· Guidance	*· Intends*	*· Likely*	*· May*	*· Might*
· Outlook	*· Plans*	*· Potential*	*· Predict*	*· Probable*
· Projects	*· Seeks*	*· Should*	*· View*	*· Will*

All statements addressing the future operating performance of CVS Health or any segment or any subsidiary and/or future events or developments, including statements relating to the projected impact of coronavirus disease 2019 ("COVID-19") and its emerging new variants on the Company's businesses, investment portfolio, operating results, cash flows and/or financial condition, statements relating to corporate strategy, statements relating to future revenue, operating income or adjusted operating income, earnings per share or adjusted earnings per share, Health Care Benefits segment business, sales results and/or trends, medical cost trends, medical membership, Medicare Part D membership, medical benefit ratios and/or operations, Pharmacy Services segment business, sales results and/or trends and/or operations, Retail/LTC segment business, sales results and/or trends and/or operations, incremental investment spending, interest expense, effective tax rate, weighted-average share count, cash flow from operations, net capital expenditures, cash available for debt repayment, integration synergies, net synergies, integration costs, enterprise modernization, transformation, leverage ratio, cash available for enhancing shareholder value, inventory reduction, turn rate and/or loss rate, debt ratings, the Company's ability to attract or retain customers and clients, store development and/or relocations, new product development, and the impact of industry and regulatory developments, as well as statements expressing optimism or pessimism about future operating results or events, are forward-looking statements within the meaning of the Reform Act.

Forward-looking statements rely on a number of estimates, assumptions and projections concerning future events, and are subject to a number of significant risks and uncertainties and other factors that could cause actual results to differ materially from those statements. Many of these risks and uncertainties and other factors are outside our control. Certain of these risks and uncertainties and other factors are described under "Risk Factors" included in Item 1A of this 10-K; these are not the only risks and uncertainties we face. There can be no assurance that the Company has identified all the risks that may affect it. Additional risks and uncertainties not presently known to the Company or that the Company currently believes to be immaterial also may adversely affect the Company's businesses. If any of those risks or uncertainties develops into actual events, those events or circumstances could have a material adverse effect on the Company's businesses, operating results, cash flows, financial condition and/or stock price, among other effects.

You should not put undue reliance on forward-looking statements. Any forward-looking statement speaks only as of the date of this 10-K, and we disclaim any intention or obligation to update or revise forward-looking statements, whether as a result of new information, future events, uncertainties or otherwise.

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PART I

Item 1. Business.

Overview

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is a leading diversified health solutions company, making healthier happen now. In an increasingly connected and digital world, we are meeting people wherever they are and changing health care to meet their needs. The Company has more than 9,900 retail locations, nearly 1,200 walk-in medical clinics, a leading pharmacy benefits manager with approximately 110 million plan members with expanding specialty pharmacy solutions and a dedicated senior pharmacy care business serving more than one million patients per year. The Company also serves an estimated 35 million people through traditional, voluntary and consumer-directed health insurance products and related services, including expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

The Company has four reportable segments: Health Care Benefits, Pharmacy Services, Retail/LTC and Corporate/ Other.

Business Strategy

The Company seeks to improve access, lower costs and enhance health outcomes by engaging with consumers when, where and how they desire. This means delivering solutions that are personalized, seamless, connected and increasingly digital. CVS Health is also shifting from transaction-based primary care to addressing holistic health – physical, emotional, social, economic – which will lead to higher quality of care and lower medical costs. The Company is a leader in key segments of health care today through foundational businesses and is seeking to create new sources of value by expanding into next generation primary care delivery and health services, with a goal of improving satisfaction levels for both providers and consumers. The Company believes its consumer-centric strategy will drive sustainable long-term growth and deliver value for all stakeholders.

COVID-19

The COVID-19 pandemic and its emerging new variants continue to impact the U.S. and other countries around the world. Our strong local presence and scale in communities across the country has enabled us to play an indispensable role in the national response to COVID-19, as well as provide seamless support for our customers wherever they need us: in our CVS locations, in their homes, and virtually.

The Company offered COVID-19 diagnostic testing at more than 4,800 CVS Pharmacy® locations, at community-based testing sites in underserved areas and through its Return Ready℠ solution as of December 31, 2021. During 2021, the Company also began selling over-the-counter ("OTC") test kits in its retail locations and online. The Company began administering COVID-19 vaccinations in long-term care facilities and in certain of its retail pharmacies during December 2020 and February 2021, respectively, and began the administration of COVID-19 boosters and pediatric vaccines during the fourth quarter of 2021. The Company offered COVID-19 vaccinations at more than 9,800 CVS Pharmacy locations as of December 31, 2021. During the year ended December 31, 2021, the Company administered more than 32 million COVID-19 tests and more than 59 million COVID-19 vaccines. The Company expects to continue to play a significant role in COVID-19 testing and vaccine administration in the future, while maintaining a strong commitment to testing and vaccine equity by optimizing site locations and targeting outreach initiatives to reach vulnerable populations.

The impact of COVID-19 on the Company's businesses, operating results, cash flows and financial condition in the years ended December 31, 2021 and 2020, as well as information regarding certain expected impacts of COVID-19 on the Company, is discussed throughout this 10-K.

Health Care Benefits Segment

The Health Care Benefits segment operates as one of the nation's leading diversified health care benefits providers, serving an estimated 35 million people as of December 31, 2021. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make more informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental and behavioral health plans, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services and health information

technology ("HIT") products and services. The Health Care Benefits segment also provided workers' compensation administrative services through its Coventry Health Care Workers' Compensation business ("Workers' Compensation business") prior to the sale of this business on July 31, 2020. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates.

Health Care Benefits Products and Services

The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk of medical and dental care costs) as "ASC." Health Care Benefits products and services consist of the following:

- *Commercial Medical*: The Health Care Benefits segment offers point-of-service ("POS"), preferred provider organization ("PPO"), health maintenance organization ("HMO") and indemnity benefit ("Indemnity") plans. Commercial medical products also include health savings accounts ("HSAs") and consumer-directed health plans that combine traditional POS or PPO and/or dental coverage, subject to a deductible, with an accumulating benefit account (which may be funded by the plan sponsor and/or the member in the case of HSAs). With the launch of Aetna Virtual Primary Care™ in 2021, eligible members now have access to health services remotely, paired with access to in-person visits with providers in the Company's network, including at MinuteClinic® and CVS HealthHUB® locations. Principal products and services are targeted specifically to large multi-site national, mid-sized and small employers, individual insureds and expatriates. The Company offers medical stop loss insurance coverage for certain employers who elect to self-insure their health benefits. Under medical stop loss insurance products, the Company assumes risk for costs associated with large individual claims and/or aggregate loss experience within an employer's plan above a pre-set annual threshold. The segment also has a portfolio of additional health products and services that complement its medical products such as dental plans, behavioral health and employee assistance products, provider network access and vision products.
- *Government Medical*: In select geographies, the Health Care Benefits segment offers Medicare Advantage plans, Medicare Supplement plans and prescription drug coverage for Medicare beneficiaries; participates in Medicaid and subsidized Children's Health Insurance Programs ("CHIP"); and participates in demonstration projects for members who are eligible for both Medicare and Medicaid ("Duals"). These Government Medical products are further described below:
    - *Medicare Advantage:* Through annual contracts with the U.S. Centers for Medicare & Medicaid Services ("CMS"), the Company offers HMO and PPO products for eligible individuals in certain geographic areas through the Medicare Advantage program. Members typically receive enhanced benefits over traditional fee-for-service Medicare coverage ("Original Medicare"), including reduced cost-sharing for preventive care, vision and other services. The Company offered network-based HMO and/or PPO plans in 46 states and Washington, D.C. in 2021. For certain qualifying employer groups, the Company offers Medicare PPO products nationally. When combined with the Company's PDP product, these national PPO plans form an integrated national Insured Medicare product for employers that provides medical and pharmacy benefits.
    - *Medicare PDP:* The Company is a national provider of drug benefits under the Medicare Part D prescription drug program. All Medicare eligible individuals are eligible to participate in this voluntary prescription drug plan. Members typically receive coverage for certain prescription drugs, usually subject to a deductible, co-insurance and/or co-payment. The Company offered PDP plans in all 50 states and Washington, D.C. in 2021. On November 30, 2018, the Company completed the sale of the standalone PDPs of Aetna, Inc. ("Aetna") to WellCare Health Plans, Inc. effective December 31, 2018. The Company provided administrative services to, and retained the financial results of, the divested plans through 2019. Subsequent to 2019, the Company no longer retains the financial results of the divested plans.
    - *Medicare Supplement:* For certain Medicare eligible members, the Company offers supplemental coverage for certain health care costs not covered by Original Medicare. The products included in the Medicare Supplement portfolio help to cover some of the gaps in Original Medicare, and include coverage for Medicare deductibles and coinsurance amounts. The Company offered a wide selection of Medicare Supplement products in 49 states and Washington, D.C. in 2021.

- *Medicaid and CHIP:* The Company offers health care management services to individuals eligible for Medicaid and CHIP under multi-year contracts with government agencies in various states that are subject to annual appropriations. CHIP are state-subsidized insurance programs that provide benefits for families with uninsured children. The Company offered these services on an Insured or ASC basis in 16 states in 2021.
- *Duals:* The Company provides health coverage to beneficiaries who are dually eligible for both Medicare and Medicaid coverage. These members must meet certain income and resource requirements in order to qualify for

this coverage. The Company coordinates 100% of the care for these members and may provide them with additional services in order to manage their health care costs.

The Company also has a portfolio of transformative products and services aimed at creating a holistic and integrated approach to individual health and wellness. These products and services complement the Commercial Medical and Government Medical products and aim to provide innovative solutions, create integrated experience offerings and enable enhanced care delivery to customers.

Health Care Benefits Provider Networks

The Company contracts with physicians, hospitals and other providers for services they provide to the Company's members. The Company uses a variety of techniques designed to help encourage appropriate utilization of medical services ("utilization") and maintain affordability of quality coverage. In addition to contracts with providers for negotiated rates of reimbursement, these techniques include creating risk sharing arrangements that align economic incentives with providers, the development and implementation of guidelines for the appropriate utilization and the provision of data to providers to enable them to improve health care quality. At December 31, 2021, the Company's underlying nationwide provider network had approximately 1.5 million participating providers. Other providers in the Company's provider networks also include laboratory, imaging, urgent care and other freestanding health facilities.

Health Care Benefits Quality Assessment

CMS uses a 5-star rating system to monitor Medicare health care and drug plans and ensure that they meet CMS's quality standards. CMS uses this rating system to provide Medicare beneficiaries with a tool that they can use to compare the overall quality of care and level of customer service of companies that provide Medicare health care and drug plans. The rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management and overall customer satisfaction. See "Health Care Benefits Pricing" below in this Item 1 for further discussion of star ratings. The Company seeks Health Plan accreditation for Aetna HMO plans from the National Committee for Quality Assurance ("NCQA"), a private, not-for-profit organization that evaluates, accredits and certifies a wide range of health care organizations. Health care plans seeking accreditation must pass a rigorous, comprehensive review and must annually report on their performance.

Aetna Life Insurance Company ("ALIC"), a wholly-owned subsidiary of the Company, has received nationwide NCQA PPO Health Plan accreditation. As of December 31, 2021, all of the Company's Commercial HMO and all of ALIC's PPO members who were eligible participated in HMOs or PPOs that are accredited by the NCQA.

The Company's provider selection and credentialing/re-credentialing policies and procedures are consistent with NCQA and URAC, a health care accrediting organization that establishes quality standards for the health care industry, as well as state and federal, requirements. In addition, the Company is certified under the NCQA Credentials Verification Organization ("CVO") certification program for all certification options and has URAC CVO accreditation.

Quality assessment programs for contracted providers who participate in the Company's networks begin with the initial review of health care practitioners. Practitioners' licenses and education are verified, and their work history is collected by the Company or in some cases by the practitioner's affiliated group or organization. The Company generally requires participating hospitals to be certified by CMS or accredited by The Joint Commission, the American Osteopathic Association, or Det Norske Veritas Healthcare.

The Company also offers quality and outcome measurement programs, quality improvement programs, and health care data analysis systems to providers and purchasers of health care services.

Health Care Benefits Information Systems

The Health Care Benefits segment currently operates and supports an end-to-end suite of information technology platforms to support member engagement, enrollment, health benefit administration, care management, service operations, financial reporting and analytics. The multiple platforms are supported by an integration layer to facilitate the transfer of real-time data. There is continued focus and investment in enterprise data platforms, cloud capabilities,

digital products to offer innovative solutions and a seamless experience to the Company's members through mobile and web channels. The Company is making concerted investments in emerging technology capabilities such as voice, artificial intelligence and robotics to further automate, reduce cost and improve the experience for all of its constituents. The Health Care Benefits segment is utilizing the

full breadth of the Company's assets to build enterprise technology that will help guide our members through their health care journey, provide them a high level of service, enable healthier outcomes and encourage them to take next best actions to lead healthier lives.

Health Care Benefits Customers

Medical membership is dispersed throughout the United States, and the Company also serves medical members in certain countries outside the United States. The Company offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, many of which are available nationwide. Depending on the product, the Company markets to a range of customers including employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans, labor groups and expatriates. For additional information on medical membership, see "Health Care Benefits Segment" in the Management's Discussion and Analysis of Financial Condition and Results of Operations (the "MD&A") included in Item 7 of this 10-K.

The Company markets both Commercial Insured and ASC products and services primarily to employers that sponsor the Company's products for the benefit of their employees and their employees' dependents. Frequently, larger employers offer employees a choice among coverage options, from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to the Company and, through payroll deductions, obtain reimbursement from employees for a percentage of the premiums that is determined by each employer. Some Health Care Benefits products are sold directly to employees of employer groups on a fully employee-funded basis. In some cases, the Company bills the covered individual directly. In addition, effective January 2022, the Company entered the individual public health insurance exchanges ("Public Exchanges") in eight states through which it sells Insured plans directly to individual consumers.

The Company offers Insured Medicare coverage on an individual basis as well as through employer groups to their retirees. Medicaid and CHIP members are enrolled on an individual basis. The Company also offers Insured health care coverage to members who are dually-eligible for both Medicare and Medicaid.

Health Care Benefits products are sold through: the Company's sales personnel; independent brokers, agents and consultants who assist in the production and servicing of business; as well as private health insurance exchanges ("Private Exchanges") and Public Exchanges (together with Private Exchanges, "Insurance Exchanges"). For large employers or other entities that sponsor the Company's products ("plan sponsors"), independent consultants and brokers are frequently involved in employer health plan selection decisions and sales. In some instances, the Company may pay commissions, fees and other amounts to brokers, agents, consultants and sales representatives who place business with the Company. In certain cases, the customer pays the broker for services rendered, and the Company may facilitate that arrangement by collecting the funds from the customer and transmitting them to the broker. The Company supports marketing and sales efforts with an advertising program that may include television, radio, billboards, print media and social media, supplemented by market research and direct marketing efforts.

The U.S. federal government is a significant customer of the Health Care Benefits segment through contracts with CMS for coverage of Medicare-eligible individuals and federal employee-related benefit programs. Other than the contracts with CMS, the Health Care Benefits segment is not dependent upon a single customer or a few customers the loss of which would have a significant effect on the earnings of the segment. The loss of business from any one, or a few, independent brokers or agents would not have a material adverse effect on the earnings of the Health Care Benefits segment. In 2021, 2020 and 2019, Health Care Benefits segment revenues from the federal government accounted for 14%, 13% and 13%, respectively, of the Company's consolidated total revenues. Contracts with CMS for coverage of Medicare-eligible individuals in the Health Care Benefits segment accounted for approximately 79%, 78% and 76%, respectively, of the Company's consolidated revenues from the federal government in 2021, 2020 and 2019.

Health Care Benefits Pricing

For Commercial Insured plans, contracts containing the pricing and other terms of the relationship are generally established in advance of the policy period and typically have a duration of one year. Fees under ASC plans are generally fixed for a period of one year.

Generally, a fixed premium rate is determined at the beginning of the policy period for Commercial Insured plans. The Company typically cannot recover unanticipated increases in health care and other benefit costs in the current policy period; however, it may consider prior experience for a product in the aggregate or for a specific customer, among other factors, in

determining premium rates for future policy periods. Where required by state laws, premium rates are filed and approved by state regulators prior to contract inception. Future operating results could be adversely affected if the premium rates requested are not approved or are adjusted downward or their approval is delayed by state or federal regulators.

The Company has Medicare Advantage and PDP contracts with CMS to provide HMO, PPO and prescription drug coverage to Medicare beneficiaries in certain geographic areas. Under these annual contracts, CMS pays the Company a fixed per member (or "capitation") payment and/or a portion of the premium, both of which are based on membership and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed capitation payment or premium. PDP contracts also provide a risk-sharing arrangement with CMS to limit the Company's exposure to unfavorable expenses or benefit from favorable expenses. Amounts payable to the Company under the Medicare arrangements are subject to annual revision by CMS, and the Company elects to participate in each Medicare service area or region on an annual basis. Premiums paid to the Company for Medicare products are subject to federal government reviews and audits, which can result, and have resulted, in retroactive and prospective premium adjustments and refunds to the government and/or members. In addition to payments received from CMS, some Medicare Advantage products and all PDP products require a supplemental premium to be paid by the member or sponsoring employer. In some cases these supplemental premiums are adjusted based on the member's income and asset levels. Compared to Commercial Medical products, Medicare contracts generate higher per member per month revenues and higher health care and other benefit costs.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA") ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star ratings." Plans must have a star rating of four or higher (out of five) to qualify for bonus payments. CMS released the Company's 2022 star ratings in October 2021. The Company's 2022 star ratings will be used to determine which of the Company's Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2023. Based on the Company's membership at December 31, 2021, 87% of the Company's Medicare Advantage members were in plans with 2022 star ratings of at least 4.0 stars, compared to 83% of the Company's Medicare Advantage members being in plans with 2021 star ratings of at least 4.0 stars based on the Company's membership at December 31, 2020.

Rates for Medicare Supplement products are regulated at the state level and vary by state and plan.

Under Insured Medicaid contracts, state government agencies pay the Company fixed monthly rates per member that vary by state, line of business and demographics; and the Company arranges, pays for and manages the health care services provided to Medicaid beneficiaries. These rates are subject to change by each state, and, in some instances, provide for adjustment for health risk factors. CMS requires these rates to be actuarially sound. The Company also receives fees from customers where it provides services under ASC Medicaid contracts. ASC Medicaid contracts generally are for periods of more than one year, and certain of them contain performance incentives and limited financial risk sharing with respect to certain medical, financial and operational metrics. Under these arrangements, performance is evaluated annually, with associated financial incentive opportunities, and financial risk share obligations are typically limited to a percentage of the fees otherwise payable to the Company. Payments to the Company under Medicaid contracts are subject to the annual appropriation process in the applicable state.

Under Duals contracts, the rate setting process is generally established by CMS in partnership with the state government agency participating in the demonstration project. Both CMS and the state government agency may seek premium and other refunds under certain circumstances, including if the Company fails to comply with CMS regulations or other contractual requirements.

The Company offers HMO and consumer-directed medical and dental plans to federal employees under the Federal Employees Health Benefits ("FEHB") Program and the Federal Employees Dental and Vision Insurance Program. Premium rates and fees for those plans are subject to federal government review and audit, which can result, and have resulted, in retroactive and prospective premium and fee adjustments and refunds to the government and/or members.

Beginning in 2014, the ACA imposed significant new industry-wide fees, assessments and taxes, including an annual levy known as the health insurer fee (the "HIF"). The HIF applied for 2020 and was temporarily suspended for 2019. In December 2019, the HIF was repealed for calendar years after 2020. For additional information on the ACA fees, assessments and taxes, see Note 1 ''Significant Accounting Policies'' included in Item 8 of this 10-K. The Company's goal is to collect premiums and fees where possible, or solve for, all of the ACA-related fees, assessments and taxes.

Health Care Benefits Seasonality

The Health Care Benefits segment's quarterly operating income progression is also impacted by (i) the seasonality of benefit costs which generally increase during the year as Insured members progress through their annual deductibles and out-of-pocket expense limits and (ii) the seasonality of operating expenses, which are generally the highest during the fourth quarter due primarily to spending to support readiness for the start of the upcoming plan year and marketing associated with Medicare annual enrollment.

During the year ended December 31, 2021, the customary quarterly operating income progression was impacted by COVID-19. While overall medical costs in the first quarter were generally consistent with historical baseline levels in the aggregate, the segment experienced increased COVID-19 testing and treatment costs and lower Medicare risk-adjusted revenue. During the second quarter, COVID-19 testing and treatment costs persisted, however at levels significantly lower than those observed during the first quarter. Beginning in the third quarter, medical costs once again increased primarily driven by the spread of the emerging new variants of COVID-19, which resulted in increased testing and treatment costs that continued throughout the fourth quarter.

During the year ended December 31, 2020, the customary quarterly operating income progression was also impacted by COVID-19. Beginning in mid-March, the health care system experienced a significant reduction in utilization that is discretionary and the cancellation of elective medical procedures. Utilization remained below historical levels through April, began to recover in May and June and reached more normal levels in the third and fourth quarters, with select geographies impacted by COVID-19 waves. The impact of the deferral of non-essential care was partially offset by COVID-19 testing and treatment costs, as well as planned COVID-19 related investments.

Health Care Benefits Competition

The health care benefits industry is highly competitive, primarily due to a large number of for-profit and not-for-profit competitors, competitors' marketing and pricing and a proliferation of competing products, including new products that are continually being introduced into the marketplace. New entrants into the marketplace, as well as consolidation within the industry, have contributed to and are expected to intensify the competitive environment. In addition, the rapid pace of change as the industry evolves towards a consumer-focused retail marketplace, including Insurance Exchanges, and the increased use of technology to interact with members, providers and customers, increase the risks the Company currently faces from new entrants and disruptive actions by existing competitors compared to prior periods.

The Company believes that the significant factors that distinguish competing health plans include the perceived overall quality (including accreditation status), quality of service, comprehensiveness of coverage, cost (including premium rates, provider discounts and member out-of-pocket costs), product design, financial stability and ratings, breadth and quality of provider networks, ability to offer different provider network options, providers available in such networks, and quality of member support and care management programs. The Company believes that it is competitive on each of these factors. The Company's ability to increase the number of persons covered by its health plans or to increase Health Care Benefits segment revenues is affected by its ability to differentiate itself from its competitors on these factors. Competition may also affect the availability of services from providers, including primary care physicians, specialists and hospitals.

Insured products compete with local and regional health care benefits plans, health care benefits and other plans sponsored by other large commercial health care benefit insurance companies, health system owned health plans, new entrants into the marketplace and numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association. The largest competitor in Medicare products is Original Medicare. Additional Health Care Benefits segment competitors include other types of medical and dental provider organizations, various specialty service providers (including pharmacy benefit management ("PBM") services providers), health care consultants, financial services companies, integrated health care delivery organizations (networks of providers who also coordinate administrative services for and assume insurance risk of their members), third party administrators ("TPAs"), HIT companies and, for certain plans, programs sponsored by the federal or state governments. Emerging competitors include start up health care benefits plans, technology companies, provider-owned health plans, new joint ventures (including not-for-profit joint ventures among firms from multiple industries), technology firms, financial services firms that are distributing competing products on their proprietary Private Exchanges, and consulting firms that are distributing competing products on their

proprietary Private Exchanges, as well as non-traditional distributors such as retail companies. The Company's ability to increase the number of persons enrolled in Insured Commercial Medical products also is affected by the desire and ability of employers to self-fund their health coverage.

The Health Care Benefits segment's ASC plans compete primarily with other large commercial health care benefit companies, numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association and TPAs.

The Health Care Benefits segment's international products compete with local, global and U.S.-based health plans and commercial health care benefit insurance companies, many of whom are licensed in more geographies and have a longer operating history, better brand recognition and greater marketplace presence in one or more geographies.

The provider solutions and HIT marketplaces and products are evolving rapidly. The Company competes for provider solutions and HIT business with other large health plans and commercial health care benefit insurance companies as well as information technology companies and companies that specialize in provider solutions and HIT. Many information technology product competitors have longer operating histories, better brand recognition, greater marketplace presence and more experience in developing innovative products.

In addition to competitive pressures affecting the Company's ability to obtain new customers or retain existing customers, the Health Care Benefits segment's medical membership has been and may continue to be adversely affected by adverse and/or uncertain economic conditions and reductions in workforce by existing customers due to adverse and/or uncertain general economic conditions, especially in the United States and industries where such membership is concentrated.

Health Care Benefits Reinsurance

The Company currently has several reinsurance agreements with non-affiliated insurers that relate to Health Care Benefits insurance policies. The Company entered into these contracts to reduce the risk of catastrophic losses which in turn reduces capital and surplus requirements. The Company frequently evaluates reinsurance opportunities and refines its reinsurance and risk management strategies on a regular basis.

Pharmacy Services Segment

The Pharmacy Services segment provides a full range of PBM solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services and mail order pharmacy. In addition, through the Pharmacy Services segment, the Company provides specialty pharmacy and infusion services, clinical services, disease management services, medical spend management and pharmacy and/or other administrative services for providers and federal 340B drug pricing program covered entities ("Covered Entities"). The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Medicaid managed care ("Managed Medicaid") plans, plans offered on Insurance Exchanges and other sponsors of health benefit plans throughout the United States and Covered Entities. The Pharmacy Services segment includes retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services. During the year ended December 31, 2021, the Company's PBM filled or managed 2.2 billion prescriptions on a 30-day equivalent basis.

PBM Services

The Company dispenses prescription drugs directly through its mail order dispensing and specialty mail order pharmacies and through pharmacies in its retail network. All prescriptions processed by the Company are analyzed, processed and documented by the Company's proprietary prescription management systems. These systems provide essential features and functionality to allow plan members to utilize their prescription drug benefits. These systems also streamline the process by which prescriptions are processed by staff and network pharmacists by enhancing review of various items through automation, including plan eligibility, early refills, duplicate dispensing, appropriateness of dosage, drug interactions or allergies, over-utilization and potential fraud.

Plan Design Offerings and Administration
The Company assists its PBM clients in designing pharmacy benefit plans that help improve health outcomes while minimizing the costs to the client. The Company also assists PBM clients in monitoring the effectiveness of their plans through frequent, informal communications, the use of proprietary software, as well as through formal annual,

quarterly and sometimes monthly performance reviews. The Company administers pharmacy benefit plans for clients who contract with it to facilitate prescription drug coverage and claims processing for their eligible plan members. The Company also provides administrative services for Covered Entities.

The Company makes recommendations to help PBM clients design benefit plans that promote the use of lower cost, clinically appropriate drugs and helps its PBM clients control costs by recommending plan designs that encourage the use of generic equivalents of brand name drugs when such equivalents are available. Clients also have the option, through plan design, to further lower their pharmacy benefit plan costs by setting different member payment levels for different products on their drug lists or "formularies," which helps guide members to choose lower cost alternatives through appropriate financial incentives.

Formulary Management
The Company utilizes an independent panel of doctors, pharmacists and other medical experts, referred to as the CVS Caremark National Pharmacy and Therapeutics Committee, to review and approve the selection of drugs that meet the Company's standards of safety and efficacy for inclusion on one of the Company's template formularies. The Company's formularies provide recommended products in numerous drug classes to help ensure member access to clinically appropriate drugs with alternatives within a class under the client's pharmacy benefit plan, while helping to drive the lowest net cost for clients that select one of the Company's formularies. To help improve clinical outcomes for members and clients, the Company conducts ongoing, independent reviews of all drugs, including those appearing on the formularies and generic equivalent products. Many of the Company's clients choose to adopt a template formulary offering as part of their plan design. PBM clients are given capabilities to offer real time benefits information for a member's specific plan design, provided digitally at the point of prescribing, at the CVS pharmacy and directly to members.

Retail Pharmacy Network Management Services
The Company maintains a national network of approximately 66,000 retail pharmacies, consisting of approximately 40,000 chain pharmacies (which includes CVS Pharmacy locations) and approximately 26,000 independent pharmacies, in the United States, including Puerto Rico, the District of Columbia, Guam and the U.S. Virgin Islands. When a customer fills a prescription in a retail pharmacy, the pharmacy sends prescription data electronically to the Company from the point-of-sale. This data interfaces with the Company's proprietary prescription management systems, which verify relevant plan member data and eligibility, while also performing a drug utilization review to help evaluate clinical appropriateness and safety and confirming that the pharmacy will receive payment for the prescription. The Company also offers a performance program for non-Medicare customers, which can be implemented with either the Company's broad, national network or with any managed network (as allowed by applicable laws and regulations). Under the program, high performing pharmacies are eligible to receive an incremental positive performance payment. The program aligns with key Healthcare Effectiveness Data Information Set measures utilized by CMS and is funded by client fees.

Mail Order Pharmacy Services
The Pharmacy Services segment operates mail order dispensing pharmacies in the United States. Plan members or their prescribers submit prescriptions or refill requests, primarily for maintenance medications, to these pharmacies, and staff pharmacists review these prescriptions and refill requests with the assistance of the Company's prescription management systems. This review may involve communications with the prescriber and, with the prescriber's approval when required, can result in generic substitution, therapeutic interchange or other actions designed to help reduce cost and/or improve quality of treatment. The Company's mail order dispensing pharmacies have been awarded Mail Service Pharmacy accreditation from URAC.

Specialty Pharmacy and Infusion Services
The Pharmacy Services segment operates specialty mail order pharmacies, retail specialty pharmacy stores and branches for infusion and enteral nutrition services in the United States. The specialty mail order pharmacies are used for delivery of advanced medications to individuals with chronic or genetic diseases and disorders. The Company's specialty mail order pharmacies have been awarded Specialty Pharmacy accreditation from URAC. Substantially all of the Company's specialty mail order pharmacies also have been accredited by The Joint Commission and the Accreditation Commission for Health Care ("ACHC"), which are independent, not-for-profit organizations that accredit and certify health care programs and organizations in the United States. The ACHC accreditation includes an additional accreditation by the Pharmacy Compounding Accreditation Board, which certifies compliance with the highest level of pharmacy compounding standards.

Clinical Services
The Company offers multiple clinical programs and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner. These programs are primarily designed to promote better health outcomes

and to help target inappropriate medication utilization and non-adherence to medication, each of which may result in adverse medical events that negatively affect member health and client pharmacy and medical spend. These programs include utilization management ("UM"), medication management, quality assurance, adherence and counseling programs to complement the client's plan design and clinical strategies. To help address prescription opioid abuse and misuse, the Company introduced an industry-leading UM approach that limits to seven days the supply of opioids dispensed for certain acute prescriptions for patients who

are new to therapy, limits the daily dosage of opioids dispensed based on the strength of the opioid and requires the use of immediate-release formulations of opioids before extended-release opioids are dispensed. The Company's Pharmacy Advisor® program facilitates pharmacist counseling, both face-to-face and over the telephone, to help participating plan members with certain chronic diseases, such as diabetes and cardiovascular conditions, to identify gaps in care, adhere to their prescribed medications and manage their health conditions. The Company also has digital connectivity that helps to lower drug costs for patients by providing expanded visibility to lower cost alternatives through enhanced analytics and data sharing.

Disease Management Programs
The Company's clinical programs and services utilize advanced protocols and offer clients convenience in working with providers and other third parties. The Company's care management program covers diseases such as rheumatoid arthritis, Parkinson's disease, epilepsy and multiple sclerosis and is accredited by the NCQA. The Company's UM program covers similar diseases and is accredited by the NCQA and URAC.

Medical Benefit Management
The Company's NovoLogix® online preauthorization tool helps identify and capture cost savings opportunities for specialty drugs billed under the medical benefit by identifying outliers to appropriate dosages and costs, and helps to ensure clinically appropriate use of specialty drugs.

Group Purchasing Organization Services
The Company operates a group purchasing organization that negotiates pricing for the purchase of pharmaceuticals and rebates with pharmaceutical manufacturers on behalf of its participants. The Company also provides various administrative, management and reporting services to pharmaceutical manufacturers.

Pharmacy Services Information Systems

The Pharmacy Services segment's claim adjudication platform incorporates architecture that centralizes the data generated from filling mail order prescriptions, adjudicating retail pharmacy claims and delivering other solutions to PBM clients. The Health Engagement Engine® technology and proprietary clinical algorithms help connect the various parts of the enterprise and serve an essential role in cost management and health improvement, leveraging cloud-native technologies and practices. This capability transforms pharmacy data into actionable interventions at key points of care, including in retail, mail and specialty pharmacies as well as in customer care call center operations, leveraging our enterprise data platform to improve the quality of care. The technology leverages assisted artificial intelligence to deliver insights to the business and bring automation to otherwise manual tasks. Specialty services also connects with our claim adjudication platform and various health plan adjudication platforms with a centralized architecture servicing many clients and members. Operating services, such as Specialty Expedite®, provide an interconnected onboarding solution for specialty medications and branding solutions ranging from fulfillment to total patient management. These services are managed through our new innovative specialty workflow and web platform.

Pharmacy Services Clients

The Company's Pharmacy Services clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D plans, Managed Medicaid plans and plans offered on Insurance Exchanges and other sponsors of health benefit plans throughout the United States and Covered Entities. Pharmaceuticals are provided to eligible members in benefit plans maintained by clients and utilize the Company's information systems, among other things, to help perform safety checks, drug interaction screening and identify opportunities for generic substitution. Substantially all of the Pharmacy Services segment's revenues are generated from dispensing and managing prescription drugs to eligible members in benefit plans maintained by clients.

Pharmacy Services Seasonality

The majority of Pharmacy Services segment revenues are not seasonal in nature.

Pharmacy Services Competition

The Company believes the primary competitive factors in the pharmacy services industry include: (i) the ability to negotiate favorable discounts from drug manufacturers as well as to negotiate favorable discounts from, and access to, retail pharmacy networks; (ii) the ability to identify and apply effective cost management programs utilizing clinical strategies, including the development and utilization of preferred formularies; (iii) the ability to market PBM products and services; (iv) the commitment

to provide flexible, clinically-oriented services to clients and be responsive to clients' needs; (v) the quality, scope and costs of products and services offered to clients and their members; and (vi) operational excellence in delivering services. The Pharmacy Services segment has a significant number of competitors offering PBM services, including large, national PBM companies (e.g., Prime Therapeutics and MedImpact), PBMs owned by large national health plans (e.g., the Express Scripts business of Cigna Corporation and the OptumRx business of UnitedHealth) and smaller standalone PBMs.

Retail/LTC Segment

The Retail/LTC segment sells prescription drugs and a wide assortment of health and wellness products and general merchandise, provides health care services through its MinuteClinic walk-in medical clinics, provides medical diagnostic testing, administers vaccinations for illnesses such as influenza, COVID-19 and shingles and conducts long-term care pharmacy ("LTC") operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to long-term care facilities and other care settings. As of December 31, 2021, the Retail/LTC segment operated more than 9,900 retail locations, nearly 1,200 MinuteClinic locations as well as online retail pharmacy websites, LTC pharmacies and on-site pharmacies. During the year ended December 31, 2021, the Retail/LTC segment filled 1.6 billion prescriptions on a 30-day equivalent basis. For the year ended December 31, 2021, the Company dispensed approximately 26.4% of the total retail pharmacy prescriptions in the United States.

Retail/LTC Products and Services

A typical retail store sells prescription drugs and a wide assortment of high-quality, nationally advertised brand name and proprietary brand merchandise. Pharmacy locations may also contract with Covered Entities under the federal 340B drug pricing program. Front store categories include over-the-counter drugs, consumer health products, beauty products and personal care products. LTC operations include distribution of prescription drugs and related consulting and ancillary services. The Company purchases merchandise from numerous manufacturers and distributors. The Company believes that competitive sources are readily available for substantially all of the products carried in its retail stores and the loss of any one supplier would not likely have a material effect on the Retail/LTC segment. The Company's MinuteClinic locations offer a variety of health care services.

Retail/LTC revenues by major product group are as follows:

	Percentage of Revenues		
	2021	**2020**	**2019**
Pharmacy [1]	76.0 %	76.9 %	76.7 %
Front store and other [2]	24.0 %	23.1 %	23.3 %
	100.0 %	100.0 %	100.0 %

(1) Pharmacy includes LTC sales and sales in pharmacies within Target Corporation ("Target") and other retail stores.

(2) "Other" represents less than 12% of the "Front store and other" revenue category in all periods presented.

Pharmacy

Pharmacy revenues represented approximately three-fourths of Retail/LTC segment revenues in each of 2021, 2020 and 2019. The Company believes that retail pharmacy operations will continue to represent a critical part of the Company's business due to industry demographics, e.g., an aging American population consuming a greater number of prescription drugs, prescription drugs being used more often as the first line of defense for managing illness, the introduction of new pharmaceutical products, the need for vaccinations, including the COVID-19 vaccination, and Medicare Part D growth. The Company believes the retail pharmacy business benefits from investment in both people and technology, as well as innovative collaborations with health plans, PBMs and providers. Given the nature of prescriptions, consumers want their prescriptions filled accurately by professional pharmacists using the latest tools and technology, and ready when promised. Consumers also need medication management programs and better information to help them get the most out of their health care dollars. To assist consumers with these needs, the Company has introduced integrated pharmacy health care services that provide an earlier, easier and more effective approach to engaging consumers in behaviors that can help lower costs, improve health and save lives.

Front Store

Front store revenues reflect the Company's strategy of innovating with new and unique products and services, using innovative personalized marketing and adjusting the mix of merchandise to match customers' needs and preferences. A key component of the front store strategy is the ExtraCare® card program, which is one of the largest and most successful retail loyalty programs in the United States. The ExtraCare program allows the Company to balance marketing efforts so it can reward its best

customers by providing them with automatic sale prices, customized coupons, ExtraBucks® rewards and other benefits. The Company also offers a subscription-based membership program, CarePass®, under which members are entitled to a suite of benefits delivered over the course of the subscription period, as well as a promotional reward that can be redeemed for future goods and services. The Company continues to launch and enhance new and exclusive brands to create unmatched offerings in beauty products and deliver other unique product offerings, including a full range of high-quality CVS Health® and other proprietary brand products that are only available through CVS stores. The Company currently carries approximately 6,000 CVS Health and proprietary items, which accounted for approximately 22% of front store revenues during 2021.

MinuteClinic
As of December 31, 2021, the Company operated nearly 1,200 MinuteClinic locations in the United States. The clinics are staffed by nurse practitioners and physician assistants who utilize nationally established guidelines to deliver a variety of health care services. Payors value these clinics because they provide convenient, high-quality, cost-effective care, in many cases offering an attractive alternative to more expensive sites of care. MinuteClinic is collaborating with the Health Care Benefits and Pharmacy Services segments to help meet the needs of the Company's health plan members and CVS Caremark's client plan members by offering programs that can improve member health and lower costs. MinuteClinic also maintains relationships with leading hospitals, clinics and physicians in the communities we serve to support and enhance quality, access and continuity of care.

On-site Pharmacies
The Company also operates a limited number of pharmacies located at client sites, which provide certain health plan members and customers with a convenient alternative for filling their prescriptions and receiving vaccinations, including the COVID-19 vaccination.

Medical Diagnostic Testing
The Company offers medical diagnostic testing primarily through its COVID-19 testing sites located at CVS Pharmacy locations, in its MinuteClinic locations, at community-based testing sites in underserved areas and through its Return Ready solution.

Long-term Care Pharmacy Operations
The Retail/LTC segment provides LTC pharmacy services through the Omnicare® business. Omnicare's customers consist of skilled nursing facilities, assisted living facilities, independent living communities, hospitals, correctional facilities, and other health care service providers. The Company provides pharmacy consulting, including monthly patient drug therapy evaluations, to assist in compliance with state and federal regulations and provide proprietary clinical and health management programs. It also provides pharmaceutical case management services for retirees, employees and dependents who have drug benefits under corporate-sponsored health care programs.

Community Location Development

CVS Health's community health destinations are an integral part of its ability to meet the needs of consumers and maintain its leadership position in the changing health care landscape. When paired with its rapidly expanding digital presence, the Company's physical presence in thousands of communities across the country represents a competitive advantage by allowing it to develop deep and trusted relationships through everyday engagement in consumer health. The Company's community health destinations have played, and will continue to play, a key role in the Company's continued growth and success. During 2021, the Company opened approximately 55 new community locations, relocated approximately 15 locations, converted approximately 300 locations into CVS HealthHUB locations and closed approximately 80 locations.

The Company's continuous assessment of its national footprint is an essential component of competing effectively in the current health care environment. On an ongoing basis, the Company evaluates changes in population, consumer buying patterns and future health needs to assess the ability of its existing stores and locations to meet the needs of its consumers and the business. During the fourth quarter of 2021, the Company completed a strategic review of its retail business and announced its plans to reduce store density in certain locations through the closure of approximately 900 stores between 2022 and 2024.

As part of the Company's strategic review of its retail business, CVS Health will also create new store formats to drive higher engagement with consumers. Three distinct models will serve as community health destinations: (a)

sites dedicated to offering primary care services; (b) an enhanced version of CVS HealthHUB locations with products and services designed for everyday health and wellness needs; and (c) traditional CVS Pharmacy stores that provide prescription services and health, wellness, personal care and other convenient retail offerings.

Retail/LTC Information Systems

The Company has continued to invest in information systems to enable it to deliver exceptional customer service, enhance safety and quality, and expand patient care services while lowering operating costs. The proprietary WeCARE Workflow tool supports pharmacy teams by prioritizing work to meet customer expectations, facilitating prescriber outreach, and seamlessly integrating clinical programs. This solution delivers improved efficiency and enhances customer experience, as well as provides a framework to accommodate the evolution of pharmacy practice and the expansion of clinical programs. Our Health Engagement Engine technology and data science clinical algorithms enable the Company to help identify opportunities for pharmacists to deliver face-to-face counseling regarding patient health and safety matters, including medication adherence issues, gaps in care and management of certain chronic health conditions. The Company's digital strategy is to empower the consumer to navigate their pharmacy experience and manage their condition through integrated online and mobile solutions that offer utility and convenience. The Company's LTC digital technology suite, Omniview®, improves the efficiency of customers' operations with tools that include executive dashboards, pre-admission pricing, electronic ordering of prescription refills, proof-of-delivery tracking, access to patient profiles, receipt and management of facility bills, and real-time validation of Medicare Part D coverage, among other capabilities.

Through the collaboration of its digital and technical teams, the Company has established critical tools which enable patients to schedule COVID-19 diagnostic testing and vaccination appointments through CVS.com and MinuteClinic.com. Key elements of the offerings include landing pages which highlight services and answer common questions, screening capabilities to determine patient eligibility, service location locator and appointment selection tools to efficiently identify the requested service on a specified date, time, and location and registration pages to collect required patient information, accelerating the administration of the test or vaccine once at the store. Once scheduled, the tools provide the user with instructions and notifications including SMS text message and email reminders, and, following administration, also provide digital results for tests and records for vaccinations, enabling patients to view and save their medical records for convenient access at a later point.

Retail/LTC Customers

The success of the Retail/LTC segment's businesses is dependent upon the Company's ability to establish and maintain contractual relationships with pharmacy benefit managers and other payors on acceptable terms. Substantially all of the Retail/LTC segment's pharmacy revenues are derived from pharmacy benefit managers, managed care organizations ("MCOs"), government funded health care programs, commercial employers and other third-party payors. No single Retail/LTC payor accounted for 10% or more of the Company's consolidated total revenues in 2021, 2020 or 2019.

Retail/LTC Seasonality

The majority of Retail/LTC segment revenues, particularly pharmacy revenues, generally are not seasonal in nature. However, front store revenues tend to be higher during the December holiday season. In addition, both pharmacy and front store revenues are affected by the timing and severity of the cough, cold and flu season. Uncharacteristic or extreme weather conditions also can adversely affect consumer shopping patterns and Retail/LTC revenues, expenses and operating results.

During the year ended December 31, 2021, the customary quarterly operating income progression continued to be impacted by COVID-19. During the first quarter, the Company experienced reduced customer traffic in its retail pharmacies, which reflected the impact of a weak cough, cold and flu season, while it administered the highest quarterly volume of COVID-19 diagnostic tests. During the second quarter, the segment generated earnings from COVID-19 vaccinations and saw improved customer traffic as vaccinated customers began more actively shopping in CVS locations. During the third and fourth quarters, emerging new variants drove the continued administration of COVID-19 vaccinations (including booster shots), which reached their highest levels of the year during the fourth quarter, and diagnostic testing. During the third and fourth quarters, the segment also generated earnings from the sale of OTC test kits in the front store.

During the year ended December 31, 2020, the customary quarterly operating income progression was also impacted by COVID-19. During March 2020, the Company experienced greater use of 90-day prescriptions, early refills of maintenance medications and increased front store volume as consumers prepared for the COVID-19 pandemic.

Subsequent to March 2020, the Company experienced reduced customer traffic in its retail pharmacies and MinuteClinic locations due to shelter-in-place orders as well as reduced new therapy prescriptions as a result of the COVID-19 pandemic. Beginning in the third quarter, the Company saw an increase in diagnostic testing related to the COVID-19 pandemic and in December 2020, the Company began administering COVID-19 vaccinations in long-term care facilities.

Retail/LTC Competition

The retail pharmacy business is highly competitive. The Company believes that it competes principally on the basis of: (i) store location and convenience, (ii) customer service and satisfaction, (iii) product selection and variety, and (iv) price. In the areas it serves, the Company competes with other drugstore chains (e.g., Walgreens and Rite Aid), supermarkets, discount retailers (e.g., Walmart), independent pharmacies, restrictive pharmacy networks, internet companies (e.g., Amazon), membership clubs, retail health clinics, urgent care and primary care offices, as well as mail order dispensing pharmacies.

LTC pharmacy services are highly regional or local in nature, and within a given geographic area of operation, highly competitive. The Company's largest LTC pharmacy competitor nationally is PharMerica. The Company also competes with numerous local and regional institutional pharmacies, pharmacies owned by long-term care facilities and local retail pharmacies. Some states have enacted "freedom of choice" or "any willing provider" requirements as part of their state Medicaid programs or in separate legislation, which may increase the competition that the Company faces in providing services to long-term care facility residents in these states.

Corporate/Other Segment

The Company presents the remainder of its financial results in the Corporate/Other segment, which primarily consists of:

- Management and administrative expenses to support the Company's overall operations, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments, expenses associated with the Company's investments in its transformation and enterprise modernization programs and acquisition-related integration costs; and
- Products for which the Company no longer solicits or accepts new customers such as large case pensions and long-term care insurance products.

Generic Sourcing Venture

The Company and Cardinal Health, Inc. ("Cardinal") each have a 50% ownership in Red Oak Sourcing, LLC ("Red Oak"), a generic pharmaceutical sourcing entity. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak. Red Oak does not own or hold inventory on behalf of either company.

Working Capital Practices

The Company funds the growth of its businesses through a combination of cash flow from operations, commercial paper and other short-term borrowings, proceeds from sale-leaseback transactions and long-term borrowings. For additional information on the Company's working capital practices, see "Liquidity and Capital Resources" in the MD&A included in Item 7 of this 10-K. Employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans (with the exception of Medicare Part D services, which are described below), labor groups and expatriates, which represent the vast majority of Health Care Benefits segment revenues, typically settle in less than 30 days. As a provider of Medicare Part D services, the Company contracts annually with CMS. Utilization of services each plan year results in the accumulation of either a receivable from or a payable to CMS. The timing of settlement of the receivable or payable with CMS takes several quarters, which impacts working capital from year to year. The majority of the Retail/LTC segment non-pharmacy revenues are paid in cash, or with debit or credit cards. Managed care organizations, pharmacy benefit managers, government funded health care programs, commercial employers and other third party insurance programs, which represent the vast majority of the Company's consolidated pharmacy revenues, typically settle in less than 30 days. The remainder of the Company's consolidated pharmacy revenues are paid in cash, or with debit or credit cards.

Human Capital

Overview

At CVS Health, we share a single, clear purpose: bringing our heart to every moment of your health. We devote significant time and attention to the attraction, development and retention of talent to deliver high levels of service to our customers. Our commitment to them includes a competitive rewards package and programs that support our diverse range of colleagues in rewarding and fulfilling careers. As of December 31, 2021, we employed approximately 300,000 colleagues primarily in the United States including in all 50 states, the District of Columbia and Puerto Rico, approximately 72% of whom were full-time.

We believe engaged colleagues produce stronger business results and are more likely to build a career with the Company. Each year we conduct an internal engagement survey that provides colleagues with an opportunity to share their opinions and experiences with respect to their role, their team and the enterprise to help our Board and our management identify areas where we can improve colleague experience. The survey covers a broad range of topics including development and opportunities, diversity management, recognition, performance, well-being, compliance and continuous improvement. In 2021, greater than 80% of our colleagues participated in the engagement survey, of which greater than 75% responded that they were actively engaged.

The Board and our chief executive officer ("CEO") provide oversight of our human capital strategy, which consists of the following categories: total rewards; diversity, equity and inclusion; colleague development; and health and safety.

Total Rewards

We recognize how vital our colleagues are to our success and strive to offer comprehensive and competitive wages and benefits to meet the varying needs of our colleagues and their families. The benefits and programs include annual bonuses, 401(k) plans, stock awards, an employee stock purchase plan, health care and insurance benefits, paid time off, flexible work schedules, family leave, dependent care resources, colleague assistance programs and tuition assistance, among many others, depending on eligibility.

In recognition of the critical role that the attraction and retention of talent plays in the success of our business, during 2021, we also announced a significant investment in our employees through an increase in the Company's minimum hourly wage to $15.00 an hour effective July 2022, with incremental increases to the Company's competitive hourly rates beginning in August 2021. The new wage structure also incorporates additional increases beyond the $15.00 minimum, with higher starting hourly rates for roles such as pharmacy technicians and call center representatives. In addition, during 2021 we awarded incremental

bonuses to select colleague groups in recognition of their ongoing contributions throughout the COVID-19 pandemic, the most significant of which included bonuses to our pharmacist and distribution center colleagues.

Diversity, Equity & Inclusion

We believe that a diverse workforce creates a healthier, stronger and more sustainable company. We aim to attract, develop, retain and support a diverse workforce that reflects the many customers, patients, members and communities we serve. Our Diversity Management Leadership Council, a cross-functional group of senior leaders appointed by our CEO, works with our Strategic Diversity Management leadership team to intentionally embed diversity across all facets of our business. For our efforts, we have been recognized as a DiversityInc Top 50 Company, a LatinaStyle Top 50 Company for Latinas and earned a 100 percent score on both the Human Rights Campaign Corporate Equality Index as well as the Disability Equality Index, meaning the company is recognized as a "Best Place to Work for Disability Inclusion." The Company discloses information on our diversity, equity and inclusion strategy and programs in our annual Corporate Social Responsibility ("CSR") Report.

As a foundation of diversity and inclusion, we continuously focus on increasing underrepresented populations across our business. In 2021, 71% of our total colleague population and 55% of our colleagues at the manager level and above self-reported as female. In addition, in 2021 our colleagues reported their race/ethnicity as: White (49%), Black/African American (17%), Hispanic/Latino (15%), Asian (11%) and Other (8%). The appendix to our CSR Report, our Strategic Diversity Management Report and our EEO-1 Employer Information Report include additional information on the diversity of our workforce.

Our diversity management strategy emphasizes workplace representation, inclusion and belonging, talent acquisition and management and a diverse marketplace. We incorporated a diversity metric into our 2021 annual cash incentive program for our most senior leaders who have the greatest ability to influence the overall hiring, development and promotion of our colleagues. We also continued the deployment of conscious inclusion training for colleagues designed to enhance awareness of biases and support inclusive behaviors. Our CSR Report includes additional information with respect to our conscious inclusion training. We support 16 Colleague Resource Groups ("CRGs") that include more than 26,000 colleagues across the enterprise. These groups represent a wide range of professional, cultural, ethical and personal affinities and interests, as well as formal mentoring programs. Our CRGs provide our colleagues with an opportunity to connect and network with one another through a particular affinity, culture or interest. Each of our CRGs is sponsored by a senior leader.

Colleague Development

The Company offers a number of resources and programs that attract, engage, develop, advance and retain colleagues. Training and development provides colleagues the support they need to perform well in their current role while planning and preparing for future roles. We offer an online orientation program that pairs new hires with seasoned colleagues and the training continues throughout a colleague's career through in-person, virtual and self-paced learning at all levels. We also provide mentoring, tools and workshops for colleagues to manage their career development. We offer a variety of management and leadership programs that develop incumbent diverse and other high potential colleagues. Our broad training practices include updated, tech-enabled tools and keep our colleagues informed of new developments in our industry that are relevant to their roles. During the year ended December 31, 2021, our colleagues invested more than 13 million hours in learning and development courses.

Our colleague development program also promotes the importance of compliance across our business. Our colleagues demonstrate this commitment through our annual Code of Conduct training, which 100% of active colleagues completed in 2021. In 2021, we launched more than 70 different training courses as part of our annual Enterprise Compliance Training Program.

Health & Safety

We have a strong commitment to providing a safe working environment. We have implemented an environmental health and safety management system to support adherence and monitoring of programs designed to make our various business operations compliant with applicable occupational safety and health regulations and requirements. Our Environmental Health and Safety Department oversees the implementation and adherence to programs like

Powered Industrial Truck training, materials handling and storage, selection of personal protective equipment and workplace violence prevention.

We utilize Safety Service Plans to analyze data and concentrate on key areas of risk to reduce the chance of workplace incidents. We focus on identifying causes and improving performance when workplace incidents occur. We also engage leaders

in promoting a culture of safety. With safety task forces in place at each distribution center, we empower leaders and safety business partners to identify policies, procedures and processes that could improve their own operations.

From the outset of the COVID-19 pandemic, we took a comprehensive approach to managing occupational health and safety challenges presented by the pandemic, including implementing facial covering requirements for our workplaces and providing face masks to colleagues, providing sick leave, implementing symptom screening measures and implementing additional protocols in accordance with applicable Occupational Safety and Health Administration ("OSHA") requirements and guidance and Centers for Disease Control and Prevention ("CDC") guidelines for workplaces. We have emphasized the importance of taking immediate steps toward full vaccination.

Environmental, Social and Governance ("ESG") Strategy

Overview

CVS Health believes the health of our people, communities and planet are linked to the health of our business. Our ESG strategy is designed to use our assets to transform the health care experience and invest in community health at the local level, while working to reduce the environmental impact of our operations. Our ESG strategy includes a set of goals we hope to achieve in 2030 or earlier. We believe these goals are achievable without materially adversely affecting our businesses, operating results, cash flows and/or prospects. Our ESG strategy consists of four pillars: *Healthy People*, *Healthy Business*, *Healthy Community* and *Healthy Planet*.

Healthy People

Through physical and virtual interactions, we provide convenient, personalized and integrated access to health care support and services. We continue to implement and expand initiatives that build on our innovative health care model, with the ultimate aim to transform the health care experience for every person we reach to improve health outcomes. These include helping to improve chronic disease prevention and management, helping to reduce and prevent prescription drug misuse, and improving the social determinants of health, which include education, transportation and behavioral health. Through our ESG strategy we are focused on our interaction with individuals across all our touchpoints to increase the likelihood that these initiatives will succeed.

Healthy Business

As we work to transform health care, we are committed to operating a healthy business for all our stakeholders, including our patients, customers, stockholders, clients, partners, communities and colleagues. Throughout our large operational footprint and including our supply chain, we are committed to acting responsibly with respect for human rights, privacy, information security, public policy, marketing and advertising. We focus on diversity, equity and inclusion as well as colleague development, health and safety. Through our ESG strategy we will be investing in colleague mentoring, sponsorship, development and advancement; workforce initiatives that provide employment services and training to the underserved; and providing access to health care while addressing health disparities.

Healthy Community

By working with community-focused organizations and through innovative programs that can be tailored to and executed across different communities, we are driving positive health outcomes and reducing overall health care costs. Through our recently announced Health Zones initiative, CVS Health and our nonprofit partners are working together to create a model that reduces health disparities, promotes and enhances equity and ensures at-risk communities can thrive. Through our ESG strategy we are building healthier communities through social impact investments, such as supporting health care professionals, reducing food insecurity, engaging our customers in community health, and coordinating care for the underserved.

Healthy Planet

Our work to improve the planet is aligned with our commitment to the communities we serve and to help protect our businesses from the negative impacts of climate change. All of our businesses, including our community locations, corporate offices and operation centers, distribution centers, and specialty pharmacy and PBM mail pharmacy locations, can be impacted by climate change-related extreme weather events and we are doing our part to reduce our

environmental impacts. We are focused on identifying resource efficiencies across our operations and supply chain. We are proud to be recognized as a leader in addressing climate-related issues and are working closely with key stakeholders to make and deliver meaningful progress. Key

priorities include the advancement of our greenhouse gas ("GHG") emissions-reduction targets, reduction in our energy consumption, the advancement of sustainability in transportation, logistics and our physical locations, which includes retrofitting community and corporate locations with LED lighting, exploring investments in renewable energy, reducing water use, focusing on smarter consumption through a "digital first" approach and the reduction of our use of paper and plastic. In October 2021, CVS Health's science-based net zero GHG emissions targets were validated by the Science Based Targets initiatives ("SBTi"). We continue to make meaningful progress to reduce our environmental impact.

Intellectual Property

The Company has registered and/or applied to register a variety of trademarks and service marks used throughout its businesses, as well as domain names, and relies on a combination of copyright, patent, trademark and trade secret laws, in addition to contractual restrictions, to establish and protect the Company's proprietary rights. The Company regards its intellectual property as having significant value in the Health Care Benefits, Pharmacy Services and Retail/LTC segments. The Company is not aware of any facts that could materially impact the continuing use of any of its intellectual property.

Government Regulation

Overview

The Company's operations are subject to comprehensive federal, state and local laws and regulations and comparable multiple levels of international regulation in the jurisdictions in which it does business. There also continues to be a heightened level of review and/or audit by federal, state and international regulators of the health and related benefits industry's business and reporting practices. In addition, many of the Company's PBM clients and the Company's payors in the Retail/LTC segment, including insurers, Medicare plans, Managed Medicaid plans and MCOs, are themselves subject to extensive regulations that affect the design and implementation of prescription drug benefit plans that they sponsor. Similarly, the Company's LTC clients, such as skilled nursing facilities, are subject to government regulations, including many of the same government regulations to which the Company is subject.

The laws and rules governing the Company's businesses and interpretations of those laws and rules continue to expand and become more restrictive each year and are subject to frequent change. The application of these complex legal and regulatory requirements to the detailed operation of the Company's businesses creates areas of uncertainty. Further, there are numerous proposed health care, financial services and other laws and regulations at the federal, state and international levels, some of which could adversely affect the Company's businesses if they are enacted. The Company cannot predict whether pending or future federal or state legislation or court proceedings will change aspects of how it operates in the specific markets in which it competes or the health care industry generally, but if changes occur, the impact of any such changes could have a material adverse impact on the Company's businesses, operating results, cash flows and/or stock price. Possible regulatory or legislative changes include the federal or one or more state governments fundamentally restructuring the Commercial, Medicare or Medicaid marketplace; reducing payments to the Company in connection with Medicare, Medicaid, dual eligible or special needs programs; increasing its involvement in drug reimbursement, pricing, purchasing, and/or importation; or changing the laws governing PBMs.

The Company has internal control policies and procedures and conducts training and compliance programs for its employees to help prevent, detect and correct prohibited practices. However, if the Company's employees or agents fail to comply with applicable laws governing its international or other operations, it may face investigations, prosecutions and other legal proceedings and actions which could result in civil penalties, administrative remedies and criminal sanctions. Any failure or alleged failure to comply with applicable laws and regulations summarized below, or any adverse applications or interpretations of, or changes in, the laws and regulations affecting the Company and/or its businesses, could have a material adverse effect on the Company's operating results, financial condition, cash flows and/or stock price. See Item 3 of this 10-K, "Legal Proceedings," for further information.

The Company can give no assurance that its businesses, financial condition, operating results and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations, including the laws and regulations described in this Government

Regulation section, as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; or (v) adverse developments

in pending or future legal proceedings against or affecting the Company, including *qui tam* lawsuits, or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

Laws and Regulations Related to COVID-19

The Families First Coronavirus Response Act (the "Families First Act") and the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") were enacted in March 2020. Each of the Families First Act and the CARES Act requires the Company to provide coverage for COVID-19 related medical services, in many cases without member cost-sharing, in its Insured Health Care Benefits products.

The CARES Act also provides relief funding to providers to reimburse them for health care related expenses incurred in preventing, preparing for and/or responding to COVID-19 (provided no other source is obligated to reimburse those expenses) or lost health care related revenues that are attributable to COVID-19. Under the CARES Act, the Company receives reimbursement for uninsured patients in connection with COVID-19 testing and vaccination as well as monoclonal antibody treatment. Aside from such reimbursement, the Company has not requested any funding under the CARES Act. However, in the second quarter of 2020, the Company received $43 million from the CARES Act provider relief fund, all of which was returned to the U.S. Department of Health and Human Services ("HHS") during the second quarter of 2020.

The CARES Act also allows for the deferral of the payment of the employer share of Social Security taxes effective March 27, 2020 by permitting them to remit the associated payments in two equal installments on or about December 31, 2021 and December 31, 2022. The Company elected to defer approximately $670 million of its Social Security tax payments during the year ended December 31, 2020. The Company paid the first of two equal installments in December 2021 and will remit the second installment on or about December 31, 2022, as required under the CARES Act.

Congress enacted the American Rescue Plan Act in March 2021. Among other changes, as a result of this legislation, Public Exchange plan premium subsidies increased for low-income individuals and became available to people with incomes higher than 400% of the federal poverty limit. These changes are currently in effect through the remainder of 2022, and Congress may extend, or potentially make permanent, these policies in subsequent legislation, which could cause continued shifts in enrollment into Public Exchange plans.

In addition to the Families First Act, the CARES Act, and the American Rescue Plan Act, the Company continues to experience new legislation, regulation, directives, orders and other requirements from federal, state, county and municipal authorities related to the COVID-19 pandemic. These governmental actions have included, but are not limited to, requirements to waive member cost-sharing associated with COVID-19 testing and treatment, provide coverage for additional COVID-19-related services, expand the use of telemedicine, extend grace periods for payments of premiums or limit coverage termination based on non-payment of premiums or fees, modify health benefits coverage eligibility rules to help maintain employee eligibility, and facilitate, accelerate or advance payments to providers, and other requirements related to the public health emergency. These requirements may impact different areas of our business differently and for different lengths of time, and present financial implications with respect to implementing and unwinding our compliance with these new requirements.

The Company has operations that fall within the scope of COVID-19 vaccine requirements for federal contractors, certain health care workers, and the requirements of certain jurisdictions such as New York City. Several of these are subject to judicial challenges. We are continuing to closely monitor and update our practices in response to developments or changes in the COVID-19 vaccination policies established by various federal agencies as well as the several state- and municipal-specific COVID-19 vaccine mandates that provide expanded exemptions, modifications, requirements or restrictions regarding employee vaccinations. We have a process for employees to request a reasonable accommodation if they are unable to get vaccinated due to a medical condition, sincerely held religious belief, or any other legally recognized exemption. Employees must apply and be approved for a reasonable accommodation in order to be exempt from the vaccination requirement.

Additionally, in December 2021, the Biden administration reiterated CARES Act guidance noting commercial health insurers are not required to cover workplace or surveillance testing and announced several new directives and actions to combat COVID-19, including the expansion of free at-home testing to be covered by commercial health insurers for the remainder of the public health emergency. On January 10, 2022, the HHS announced that commercial health

insurers must cover the costs of up to eight rapid OTC COVID-19 test kits per individual per 30-day period. This requirement will likely impact multiple business operations, including increasing benefit costs in our commercial health insurance business and increasing revenues in our retail business. The requirement may also result in a decrease in more expensive tests and treatments, which could partially mitigate the increase in benefit costs in our commercial health insurance business. These impacts will be highly dependent on the overall supply of testing products.

The impact of this governmental activity on the U.S. economy, consumer, customer and health care provider behavior and health care utilization patterns is beyond our knowledge and control. As a result, the financial and/or operational impact these COVID-19 related governmental actions and inactions will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the collective impact could be material and adverse.

Laws and Regulations Related to Multiple Segments of the Company's Business

Laws Related to Reimbursement by Government Programs - The Company is subject to various federal and state laws concerning its submission of claims and other information to Medicare, Medicaid and other federal and state government-sponsored health care programs. Potential sanctions for violating these laws include recoupment or reduction of government reimbursement amounts, civil penalties, treble damages, and exclusion from participation in government health care programs. Such laws include the federal False Claims Act (the "False Claims Act"), the federal anti-kickback statute (the "AKS"), state false claims acts and anti-kickback statutes in most states, the federal "Stark Law" and related state laws. In particular, the False Claims Act prohibits intentionally submitting, conspiring to submit, or causing to be submitted, false claims, records, or statements to the federal government, or intentionally failing to return overpayments, in connection with reimbursement by federal government programs. In addition, any claim for government reimbursement also violates the False Claims Act where it results from a violation of the AKS.

Both federal and state false claims laws permit private individuals to file *qui tam* or "whistleblower" lawsuits on behalf of the federal or state government. Participants in the health and related benefits industry, including the Company, frequently are subject to actions under the False Claims Act or similar state laws. The federal Stark Law generally prohibits physicians from referring Medicare or Medicaid beneficiaries for certain services, including outpatient prescription drugs, to any entity with which the physician, or an immediate family member of the physician, has a financial relationship. The Stark Law further prohibits the entity receiving a prohibited referral from presenting a claim for reimbursement by Medicare or Medicaid for services furnished pursuant to the prohibited referral. Various states have enacted similar laws.

The ACA - The ACA significantly increased federal and state oversight of health plans. Among other requirements, it specifies minimum medical loss ratios ("MLRs") for Commercial and Medicare Insured products, specifies features required to be included in commercial benefit designs, limits commercial individual and small group rating and pricing practices, encourages additional competition (including potential incentives for new participants to enter the marketplace), and includes regulations and processes that could delay or limit the Company's ability to appropriately increase its health plan premium rates. This in turn could adversely affect the Company's ability to continue to participate in certain product lines and/or geographies that it serves today.

In June 2021, the United States Supreme Court dismissed a challenge on procedural grounds that argued the ACA is unconstitutional in its entirety and issued an opinion preserving the ACA and its consumer protections in its current form. Even though the ACA was deemed constitutional, there may nevertheless be continued efforts to invalidate, modify, repeal or replace portions of it. In addition to litigation, parts of the ACA continue to evolve through the promulgation of executive orders, legislation, regulations and guidance at the federal or state level. The Company expects the ACA, including potential changes thereto, to continue to significantly impact its business operations and operating results, including pricing, medical benefit ratios ("MBRs") and the geographies in which the Company's products are available.

Medicare Regulation - The Company's Medicare Advantage products compete directly with Original Medicare and Medicare Advantage products offered by other Medicare Advantage organizations and Medicare Supplement products offered by other insurers. The Company's Medicare PDP and Medicare Supplement products are products that Medicare beneficiaries who are enrolled in Original Medicare purchase to enhance their Original Medicare coverage.

The Company continues to expand the number of counties in which it offers Medicare products. The Company has expanded its Medicare service area and products in 2022 and is seeking to substantially grow its Medicare membership, revenue and operating results over the next several years, including through growth in Medicare Supplement products. The anticipated organic expansion of the Medicare service area and Medicare products offered and the Medicare-related provisions of the ACA significantly increase the Company's exposure to funding and

regulation of, and changes in government policy with respect to and/or funding or regulation of, the various Medicare programs in which the Company participates, including changes in the amounts payable to us under those programs and/or new reforms or surcharges on existing programs. For example, the ACA requires minimum MLRs for Medicare Advantage and Medicare Part D plans of 85%. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS.

Due to potential lower utilization of medical services by Medicare beneficiaries during the COVID-19 pandemic, it is possible certain Medicare Advantage contracts may not meet the 85% MLR for consecutive years.

The Company's Medicare Advantage and PDP products are heavily regulated by CMS. The regulations and contractual requirements applicable to the Company and other private participants in Medicare programs are complex, expensive to comply with and subject to change. For example, the Medicare Advantage Overpayment Rule, issued in 2014, implemented the ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. Failure to notify overpayments to CMS could result in liability under the False Claims Act. The precise interpretation, impact and legality of this rule are subject to pending litigation. Payments the Company receives from CMS for its Medicare Advantage and Part D businesses also are subject to risk adjustment based on the health status of the individuals enrolled. Elements of that risk adjustment mechanism continue to be challenged by the U.S. Department of Justice (the "DOJ"), the Office of the Inspector General of the HHS (the "OIG") and CMS itself. Substantial changes in the risk adjustment mechanism, including changes that result from enforcement or audit actions, could materially affect the amount of the Company's Medicare reimbursement, require the Company to raise prices or reduce the benefits offered to Medicare beneficiaries, and potentially limit the Company's (and the industry's) participation in the Medicare program.

The Company has invested significant resources to comply with Medicare standards, and its Medicare compliance efforts will continue to require significant resources. CMS may seek premium and other refunds, prohibit the Company from continuing to market and/or enroll members in or refuse to passively enroll members in one or more of the Company's Medicare or Medicare-Medicaid demonstration (historically known as "dual eligible") plans, exclude us from participating in one or more Medicare, dual eligible or dual eligible special needs plan programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS regulations or its Medicare contractual requirements. The Company's Medicare Supplement products are regulated at the state level and subject to similar significant compliance requirements and risks.

In addition, in November 2020, the HHS released the final Rebate Rule (the "Rebate Rule"), which eliminates the regulatory safe harbor from prosecution under the AKS for rebates from pharmaceutical companies to PBMs in Medicare Part D, replacing it with two far narrower safe harbors designed to directly benefit patients with high out-of-pocket costs and to change the way PBMs are compensated. The new safe harbors are (i) for rebates which are passed on to the patient at the point of sale and (ii) for flat service fee payments made to PBMs which cannot be tied to the list prices of drugs. It is unclear whether the Rebate Rule will be enforceable, whether pharmaceutical companies will respond by reducing list prices, whether list prices in the private market may also be reduced, and what the resulting impact will be to PBMs or the Company. The Pharmaceutical Care Management Association (the "PCMA"), which represents PBMs, has filed a suit in an effort to block the Rebate Rule, claiming that the Rebate Rule would lead to higher premiums in Medicare Part D and was adopted in an unlawful manner. The Bipartisan Infrastructure Act of 2021 delays the effective date of the rebate rule to January 2026, and pending Reconciliation legislation would fully repeal the Rebate Rule.

In December 2021, President Biden signed the Protecting Medicare and American Farmers from Sequester Cuts Act. The legislation extends the suspension of the 2% Medicare sequester cuts until March 2022. Starting in April 2022, the Medicare sequester cuts will be phased back in with a 1% cut that will continue through June. Absent any further changes by Congress, the 2% Medicare sequester would be fully implemented again effective July 1, 2022. Congress suspended the Medicare sequester cuts due to the COVID-19 pandemic, providing a continued increase in Medicare Advantage and Part D plan payments, as well as Medicare fee-for-service provider payments. The legislation also includes a 3% increase in the Medicare Physician Fee Schedule payments for 2022. Congress enacted a similar increase of 3.75% for 2021 which was set to expire. As a result of this increase, Medicare Advantage plans who have contracts with providers based on the Medicare Physician Fee Schedule will need to increase their payment rates by 3%. This increase became effective in January 2022 and does not include any allowance for the increased Medicare Advantage costs that result from the provision. Taken together, the two provisions represent a modest increase in Medicare Advantage costs relative to our expectations for 2022.

Currently, Congress is considering legislation to add additional benefits to Medicare Part B, such as dental, hearing and vision benefits. The Congressional Budget Office has not yet scored any of the proposals.

Going forward, the Company expects CMS, the OIG, the DOJ, other federal agencies and the U.S. Congress to continue to scrutinize closely each component of the Medicare program (including Medicare Advantage, PDPs,

demonstration projects such as Medicare-Medicaid plans and provider network access and adequacy), modify the terms and requirements of the program and possibly seek to recast or limit private insurers' roles. It is also possible that Congress may reform the structure of the Medicare Part D program and may consider changes to Medicare Advantage payment policies due to recent recommendations by the Medicare Payment Advisory Commission and to reduce the potential added cost burden of costly new

benefits, or policies that impact drug pricing such as price controls and inflationary rebates applied to pharmaceutical manufacturers.

It is not possible to predict the outcome of such regulatory or Congressional activity, any of which could materially and adversely affect the Company.

Medicare Audits - CMS regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare Advantage and PDP beneficiaries. For example, CMS conducts risk adjustment data validation ("RADV") audits of a subset of Medicare Advantage contracts for each contract year. Since 2011, CMS has selected certain of the Company's Medicare Advantage contracts for various years for RADV audit, and the number of RADV audits continues to increase. The OIG also is auditing the Company's risk adjustment data and that of other companies, and the Company expects CMS and the OIG to continue auditing risk adjustment data. The Company also has received Civil Investigative Demands ("CIDs") from, and provided documents and information to, the Civil Division of the DOJ in connection with a current investigation of its patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

In October 2018, CMS issued proposed rules related to, among other things, changes to the RADV audit methodology established by CMS in 2012. CMS projects that the changes to the RADV audit methodology would increase its recoveries from Medicare Advantage plans as a result of RADV audits. CMS has requested comments on the proposed rules, including whether the proposed RADV rule change should apply retroactively to audits of Medicare Advantage plans for contract year 2011 and forward, and gave notice that it has extended the timeline for publication of the final rules until November 2022. While the Company submitted timely comments to the proposed rules, if they are adopted as proposed there may be potential adverse effects, which could be material, on the Company's operating results, financial condition, and cash flows. CMS also has announced that its goal is to subject all Medicare Advantage contracts to either a comprehensive or a targeted RADV audit for each contract year.

Medicare Star Ratings - A portion of each Medicare Advantage plan's reimbursement is tied to the plan's "star ratings." The star rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management, compliance and overall customer satisfaction. Only Medicare Advantage plans with an overall star rating of four or more stars (out of five stars) are eligible for a quality bonus in their basic premium rates. As a result, the Company's Medicare Advantage plans' operating results in 2022 and going forward will be significantly affected by their star ratings. The Company's star ratings and past performance scores are adversely affected by the compliance issues that arise each year in its Medicare operations. CMS released the Company's 2022 star ratings in October 2021. The Company's 2022 star ratings will be used to determine which of its Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2023. Based on the Company's membership at December 31, 2021, 87% of the Company's Medicare Advantage members were in plans with 2022 star ratings of at least 4.0 stars. CMS also gives PDPs star ratings which affect each PDP's enrollment. Medicare Advantage and PDP plans that are rated less than three stars for three consecutive years are subject to contract termination by CMS. CMS continues to revise its star ratings system to make it harder to achieve four stars or more. Despite the Company's success in achieving high 2022 star ratings and other quality measures and the continuation of its improvement efforts, there can be no assurances that it will be successful in maintaining or improving its star ratings in future years. Accordingly, the Company's Medicare Advantage plans may not be eligible for full level quality bonuses, which could adversely affect the benefits such plans can offer, reduce membership and/or reduce profit margins.

Medicare Benchmark Rates - In January 2021, CMS issued its final notice detailing final 2022 Medicare Advantage benchmark payment rates. Final 2022 Medicare Advantage rates resulted in an increase in industry benchmark rates of approximately 4.1%. This rate increase only partially offsets the challenge the Company faces from the impact of the increasing cost of medical care (including prescription medications) and CMS local and national coverage decisions that require the Company to pay for services and supplies that are not factored into the Company's bids. The federal government may seek to impose restrictions on the configuration of pharmacy or other provider networks for Medicare Advantage and/or PDP plans, or otherwise restrict the ability of these plans to alter benefits, negotiate prices or establish other terms to improve affordability or maintain viability of products. The Company currently believes that the payments it has received and will receive in the near term are adequate to justify the Company's continued participation in the Medicare Advantage and PDP programs, although there are economic and political pressures to continue to reduce spending on the program, and this outlook could change.

340B Drug Pricing Program – The 340B Drug Pricing Program allows eligible Covered Entities to purchase prescription drugs from manufacturers at a steep discount, and is overseen by the HHS and the Health Resources and Services Administration ("HRSA"). In 2020, a number of pharmaceutical manufacturers began programs that limited Covered Entities' participation in the program through contract pharmacies arrangements. In May 2021, HRSA sent enforcement letters to

multiple manufacturers to curb these practices. In September 2021, HRSA forwarded the enforcement actions to the OIG for potential imposition of civil monetary penalties. Those enforcement actions are currently subject to ongoing litigation. A reduction in Covered Entities' participation in contract pharmacy arrangements, as a result of the pending enforcement actions or otherwise, a reduction in the use of the Company's administrative services by Covered Entities, or a reduction in drug manufacturers' participation in the program could materially and adversely affect the Company.

Anti-Remuneration Laws - Federal law prohibits, among other things, an entity from knowingly and willfully offering, paying, soliciting or receiving, subject to certain exceptions and "safe harbors," any remuneration to induce the referral of individuals or the purchase, lease or order of items or services for which payment may be made under Medicare, Medicaid or certain other federal and state health care programs. A number of states have similar laws, some of which are not limited to services paid for with government funds. Sanctions for violating these federal and state anti-remuneration laws may include imprisonment, criminal and civil fines, and exclusion from participation in Medicare, Medicaid and other federal and state government-sponsored health care programs. Companies involved in public health care programs such as Medicare and/or Medicaid are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The Company has invested significant resources to comply with Medicare and Medicaid program standards. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that the Company's compliance efforts in this area will continue to require significant resources.

Antitrust and Unfair Competition - The U.S. Federal Trade Commission ("FTC") investigates and prosecutes practices that are "unfair trade practices" or "unfair methods of competition." Numerous lawsuits have been filed throughout the United States against pharmaceutical manufacturers, retail pharmacies and/or PBMs under various federal and state antitrust and unfair competition laws challenging, among other things: (i) brand name drug pricing and rebate practices of pharmaceutical manufacturers, (ii) the maintenance of retail or specialty pharmacy networks by PBMs, and (iii) various other business practices of PBMs and retail pharmacies. In July 2021, the FTC approved several resolutions that direct agency staff to use compulsory process, such as subpoenas, to investigate seven specific enforcement priorities. Priority targets include, among other businesses, health care businesses, such as pharmaceutical companies, pharmacy benefits managers and hospitals. To the extent that the Company appears to have actual or potential market power in a relevant market or CVS Pharmacy, CVS Specialty or MinuteClinic plays a unique or expanded role in a Health Care Benefits or Pharmacy Services segment product offering, the Company's business arrangements and uses of confidential information may be subject to heightened scrutiny from an anti-competitive perspective and possible challenge by state and/or federal regulators and/or private parties.

Privacy and Confidentiality Requirements - Many of the Company's activities involve the receipt, use and disclosure by the Company of personally identifiable information ("PII") as permitted in accordance with applicable federal and state privacy and data security laws, which require organizations to provide appropriate privacy and security safeguards for such information. In addition to PII, the Company uses and discloses de-identified data for analytical and other purposes when permitted. Additionally, there are industry standards for handling credit card data known as the Payment Card Industry Data Security Standard, which are a set of requirements designed to help ensure that entities that process, store or transmit credit card information maintain a secure environment. Certain states have incorporated these requirements into state laws or enacted other requirements relating to the use and/or disclosure of PII.

The federal Health Insurance Portability and Accountability Act of 1996 and the regulations issued thereunder (collectively, "HIPAA"), as further modified by the American Recovery and Reinvestment Act of 2009 ("ARRA") impose extensive requirements on the way in which health plans, providers, health care clearinghouses (known as "covered entities") and their business associates use, disclose and safeguard protected health information ("PHI"). Further, ARRA requires the Company and other covered entities to report any breaches of PHI to impacted individuals and to the HHS and to notify the media in any states where 500 or more people are impacted by the unauthorized release or use of or access to PHI. Criminal penalties and civil sanctions may be imposed for failing to comply with HIPAA standards. The Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), enacted as part of ARRA, amended HIPAA to impose additional restrictions on third-party funded communications using PHI and the receipt of remuneration in exchange for PHI. The HITECH Act also extended HIPAA privacy and security requirements and penalties directly to business associates. HHS has begun to audit health plans, providers and other parties to enforce HIPAA compliance, including with respect to data security.

In addition to HIPAA, state health privacy laws apply to the extent they are more protective of individual privacy than is HIPAA, including laws that place stricter controls on the release of information relating to specific diseases or conditions and requirements to notify members of unauthorized release or use of or access to PHI. States also have adopted regulations to implement provisions of the Financial Modernization Act of 1999 (also known as the Gramm-Leach-Bliley Act ("GLBA")) which generally require insurers, including health insurers, to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer

shares such information with a non-affiliated third party. Like HIPAA, GLBA sets a “floor” standard, allowing states to adopt more stringent requirements governing privacy protection. Complying with additional state requirements requires us to make additional investments beyond those the Company has made to comply with HIPAA and GLBA.

The Cybersecurity Information Sharing Act of 2015 encourages organizations to share cyber threat indicators with the federal government and, among other things, directs HHS to develop a set of voluntary cybersecurity best practices for organizations in the health care industry. In addition, states have begun to enact more comprehensive privacy laws and regulations addressing consumer rights to data access, deletion, protection or transparency, such as the California Consumer Privacy Act (“CCPA”). States also are starting to issue regulations and proposed regulations specifically related to cybersecurity, such as the regulations issued by the New York Department of Financial Services. Complying with conflicting cybersecurity regulations, which may differ from state to state, requires significant resources. In addition, differing approaches to state privacy and/or cyber-security regulation and varying enforcement philosophies may materially and adversely affect the Company’s ability to standardize its products and services across state lines. Widely-reported large scale commercial data breaches in the United States and abroad increase the likelihood that additional data security legislation will be considered by additional states. These legislative and regulatory developments will impact the design and operation of the Company’s businesses, its privacy and security strategy and its web-based and mobile assets.

Finally, each Public Exchange is required to adhere to privacy and security standards with respect to PII, and to impose privacy and security standards that are at least as protective of PII as those the Public Exchange has implemented for itself or non-Public Exchange entities, which include insurers offering plans through the Public Exchange and their designated downstream entities, including PBMs and other business associates. These standards may differ from, and be more stringent than, HIPAA.

Consumer Protection Laws - The federal government has many consumer protection laws, such as the Federal Trade Commission Act, the Federal Postal Service Act and the Consumer Product Safety Act. Most states also have similar consumer protection laws and a growing number of states regulate subscription programs. In addition, the federal government and most states have adopted laws and/or regulations requiring places of public accommodation, health care services and other goods and services to be accessible to people with disabilities. These consumer protection and accessibility laws and regulations have been the basis for investigations, lawsuits and multistate settlements relating to, among other matters, the marketing of loyalty programs, and health care products and services, pricing accuracy, expired front store products, financial incentives provided by drug manufacturers to pharmacies in connection with therapeutic interchange programs, disclosures related to how personal data is used and protected and the accessibility of goods and services to people with disabilities. As a result of the Company’s direct-to-consumer activities, including mobile and web-based solutions offered to members and to other consumers, the Company also is subject to federal and state regulations applicable to electronic communications and to other general consumer protection laws and regulations. For example, the CCPA became effective in 2020, and additional federal and state regulation of consumer privacy protection may be proposed or enacted in 2020. The Company expects these new laws and regulations to impact the design of its products and services and the management and operation of its businesses and to increase its compliance costs.

Transparency in Coverage Rule - In October 2020, the HHS, the U.S. Department of Labor (“DOL”) and the U.S. Internal Revenue Service (“IRS,” and together with the HHS and DOL, the “Tri-Departments”) released a final rule requiring health insurers to disclose negotiated prices of drugs, medical services, supplies and other covered items. The rule requires group health plans and health insurance issuers in the individual and group markets to disclose cost-sharing information upon request, to a participant, beneficiary, or enrollee and require plans and issuers to publicly disclose in-network provider rates, historical out-of-network allowed amounts and the associated billed charges, and negotiated rates and historical net prices for prescription drugs. Disclosure of data in a machine readable file is required beginning in January 2022, and insurers are required to have a consumer tool in place by January 2023. In August 2021, the federal government delayed enforcement of the requirement to publish machine-readable files for in-network rates, out-of-network allowed amounts and billed charges until July 2022. It also delayed enforcement of machine-readable files related to prescription drug pricing until further rulemaking occurs. The public disclosure of insurer- or PBM-negotiated price concessions may result in drug manufacturers lowering discounts or rebates, resulting in higher drug costs for patients and impacting the ability of the Company to negotiate drug prices and provide competitive products and services to consumers.

Additionally, the Consolidated Appropriations Act of 2021 was signed into law in December 2020 and contains further transparency provisions requiring group health plans and health insurance issuers to report certain prescription drug costs, overall spending on health services and prescription drugs, and information about premiums and the impact of rebates and other remuneration on premiums and out-of-pocket costs to the Tri-Departments. No later than 18 months after the first submission and bi-annually thereafter, the Tri-Departments will release a public report on drug pricing trends, drug reimbursement, and the

impact of drug prices on premiums. In August, the Tri-Departments deferred enforcement of both the December 2021 deadline for reporting 2020 plan year data and the June 2022 deadline for reporting 2021 plan year data to December 2022.

Telemarketing and Other Outbound Contacts - Certain federal and state laws, such as the Telephone Consumer Protection Act and the Telemarketing Sales Rule, give the FTC, the Federal Communications Commission and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Pharmacy and Professional Licensure and Regulation - The Company is subject to a variety of intersecting federal and state statutes and regulations that govern the wholesale distribution of drugs; operation of retail, specialty, infusion, LTC and mail order pharmacies; licensure of facilities and professionals, including pharmacists, technicians, nurses and other health care professionals; registration of facilities with the U.S. Drug Enforcement Administration (the "DEA") and analogous state agencies that regulate controlled substances; packaging, storing, shipping and tracking of pharmaceuticals; repackaging of drug products; labeling, medication guides and other consumer disclosures; interactions with prescribers and health care professionals; compounding of prescription medications; dispensing of controlled and non-controlled substances; counseling of patients; transfers of prescriptions; advertisement of prescription products and pharmacy services; security; inventory control; recordkeeping; reporting to Boards of Pharmacy, the U.S. Food and Drug Administration (the "FDA"), the U.S. Consumer Product Safety Commission, the DEA and related state agencies; and other elements of pharmacy practice. Pharmacies are highly regulated and have contact with a wide variety of federal, state and local agencies with various powers to investigate, inspect, audit or solicit information, including Boards of Pharmacy and Nursing, the DEA, the FDA, the DOJ, HHS and others. Many of these agencies have broad enforcement powers, conduct audits on a regular basis, can impose substantial fines and penalties, and may revoke the license, registration or program enrollment of a facility or professional.

State Insurance, HMO and Insurance Holding Company Regulation - A number of states regulate affiliated groups of insurers and HMOs such as the Company under holding company statutes. These laws may, among other things, require prior regulatory approval of dividends and material intercompany transfers of assets and transactions between the regulated companies and their affiliates, including their parent holding companies. The Company expects the states in which its insurance and HMO subsidiaries are licensed to continue to expand their regulation of the corporate governance and internal control activities of its insurance companies and HMOs. Changes to state insurance, HMO and/or insurance holding company laws or regulations or changes to the interpretation of those laws or regulations, including due to regulators' increasing concerns regarding insurance company and/or HMO solvency due, among other things, to past and expected payor insolvencies, could negatively affect the Company's businesses in various ways, including through increases in solvency fund assessments, requirements that the Company hold greater levels of capital and/or delays in approving dividends from regulated subsidiaries.

PBM offerings of prescription drug coverage under certain risk arrangements may be subject to laws and regulations in various states. Such laws may require that the party at risk become licensed as an insurer, establish reserves or otherwise demonstrate financial viability. Laws that may apply in such cases include insurance laws and laws governing MCOs and limited prepaid health service plans. In addition, several states require that PBMs become directly registered or licensed with the department of insurance or similar government oversight agency regardless of any arrangements they have with clients. PBM licensure laws may include oversight of certain PBM activities and operations and may include auditing of those activities.

The states of domicile of the Company's regulated subsidiaries have statutory risk-based capital ("RBC") requirements for health and other insurance companies and HMOs based on the National Association of Insurance Commissioners' (the "NAIC") Risk-Based Capital for Insurers Model Act (the "RBC Model Act"). These RBC requirements are intended to assess the capital adequacy of life and health insurers and HMOs, taking into account the risk characteristics of a company's investments and products. The RBC Model Act sets forth the formula for calculating RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual company's business. In general, under these laws, an insurance company or HMO must submit a report of its RBC level to the insurance department or insurance commissioner of

its state of domicile for each calendar year. At December 31, 2021, the RBC level of each of the Company's insurance and HMO subsidiaries was above the level that would require regulatory action.

For information regarding restrictions on certain payments of dividends or other distributions by the Company's HMO and insurance company subsidiaries, see Note 12 ''Shareholders' Equity'' included in Item 8 of this 10-K.

The holding company laws for the states of domicile of certain of the Company's subsidiaries also 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 (such as the

Company's ultimate parent company, CVS Health Corporation) that controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would control the insurance holding company. Control is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person.

Certain states have laws that prohibit submitting a false claim or making a false record or statement in order to secure reimbursement from an insurance company. These state laws vary, and violation of them may lead to the imposition of civil or criminal penalties.

Government Agreements and Mandates - From time to time, the Company and/or its various affiliates are subject to certain consent decrees, settlement and other agreements, corrective action plans and corporate integrity agreements with various federal, state and local authorities relating to such matters as privacy practices, controlled substances, PDPs, expired products, environmental and safety matters, marketing and advertising practices, PBM, LTC and other pharmacy operations and various other business practices. Certain of these agreements contain ongoing reporting, monitoring and/or other compliance requirements for the Company. Failure to meet the Company's obligations under these agreements could result in civil or criminal remedies, financial penalties, administrative remedies, and/or exclusion from participation in federal health care programs.

Environmental and Safety Regulation - The Company's businesses are subject to various federal, state and local laws, regulations and other requirements pertaining to protection of the environment, public health and employee safety, including, for example, regulations governing the management of hazardous substances, the cleaning up of contaminated sites, and the maintenance of safe working conditions in the Company's retail locations, distribution centers and other facilities. Governmental agencies at the federal, state and local levels continue to focus on the retail and health care sectors' compliance with such laws and regulations, and have at times pursued enforcement activities. Any failure to comply with these regulations could result in fines or other sanctions by government authorities.

ERISA Regulation - The Employee Retirement Income Security Act of 1974 ("ERISA"), provides for comprehensive federal regulation of certain employee pension and benefit plans, including private employer and union sponsored health plans and certain other plans that contract with us to provide PBM services. In general, the Company assists plan sponsors in the administration of their health benefit plans, including the prescription drug benefit portion of those plans, in accordance with the plan designs adopted by the plan sponsors. In addition, the Company may have fiduciary duties where it has specifically contracted with a plan sponsor to accept limited fiduciary responsibility, such as for the adjudication of initial prescription drug benefit claims and/or the appeals of denied claims under a plan. In addition to its fiduciary provisions, ERISA imposes civil and criminal liability on service providers to health plans and certain other persons if certain forms of illegal remuneration are made or received. These provisions of ERISA are broadly written and their application to specific business practices is often uncertain.

Some of the Company's health and related benefits and large case pensions products and services and related fees also are subject to potential issues raised by judicial interpretations relating to ERISA. Under those interpretations, together with DOL regulations, the Company may have ERISA fiduciary duties with respect to PBM members and/or certain general account assets held under contracts that are not guaranteed benefit policies. As a result, certain transactions related to those general account assets are subject to conflict of interest and other restrictions, and the Company must provide certain disclosures to policyholders annually. The Company must comply with these restrictions or face substantial penalties.

In addition, ERISA generally preempts all state and local laws that relate to employee benefit plans, but the extent of the pre-emption continues to be reviewed by courts, including the U.S. Supreme Court. For example, in December 2020, the U.S. Supreme Court upheld an Arkansas law that, among other things, mandates a particular pricing methodology, establishes an appeals process for a pharmacy when the reimbursement is below the pharmacy's acquisition cost, permits a pharmacy to reverse and rebill if they cannot procure the drug from its wholesaler at a price equal to or less than the reimbursement rate, prohibits a PBM from reimbursing a pharmacy less than the amount it reimburses an affiliate on a per unit basis, and permits a pharmacy to decline to dispense if the reimbursement is lower than the pharmacy's acquisition cost. Also, in November 2021, the U.S. Court of Appeals for the Eighth Circuit upheld a North Dakota law that regulates employer-sponsored ERISA health plans and certain PBM practices within Medicare.

Other Legislative Initiatives and Regulatory Initiatives - The U.S. federal and state governments, as well as governments in other countries where the Company does business, continue to enact and seriously consider many broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system and the Company's businesses, operating results and/or cash flows. For example:

- Under the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012 significant, automatic across-the-board budget cuts (known as sequestration) began in March 2013, including Medicare spending cuts of not more than 2% of total program costs per year through 2024. Since then, Congress has extended and modified sequestration a number of times. The CARES Act temporarily suspended Medicare sequestration from May 2020 to the end of December 2020 and extended mandatory sequestration to 2030. Several subsequent acts have extended the temporary suspension of Medicare sequestration through the end of March 2022, at which point a 1% sequestration will take effect April 2022 through June 2022, with the full 2% sequestration due to resume in July 2022. Significant uncertainty remains as to whether and how the U.S. Congress will proceed with actions that create additional federal revenue and/or with entitlement reform. The Company cannot predict future federal Medicare or federal or state Medicaid funding levels or the impact that future federal or state budget actions or entitlement program reform, if it occurs, will have on the Company's businesses, operations or operating results, but the effects could be materially adverse, particularly on the Company's Medicare and/or Medicaid revenues, MBRs and operating results.
- The European Union's ("EU's") General Data Protection Regulation ("GDPR") began to apply across the EU during 2018.
- Other significant legislative and/or regulatory measures which are or recently have been under consideration include the following:
    - Increasing the corporate tax rate.
    - Eliminating payment of manufacturer's rebates on prescription drugs to PBMs, PDPs and Managed Medicaid organizations in connection with federally funded health care programs.
    - Imposing requirements and restrictions on the design and/or administration of pharmacy benefit plans offered by the Company's and its clients' health plans and/or its PBM clients and/or the services the Company provides to those clients, including prohibiting "differential" or "spread" pricing in PBM contracts; restricting or eliminating the use of formularies for prescription drugs; restricting the Company's ability to require members to obtain drugs through a home delivery or specialty pharmacy; restricting the Company's ability to place certain specialty or other drugs in the higher cost tiers of its pharmacy formularies; restricting the Company's ability to make changes to drug formularies and/or clinical programs; limiting or eliminating rebates on pharmaceuticals; requiring the use of up front purchase price discounts on pharmaceuticals in lieu of rebates; restricting the Company's ability to configure and reimburse its health plan and retail pharmacy provider networks, including use of CVS Pharmacy locations; and restricting or eliminating the use of certain drug pricing methodologies.
    - Increasing federal or state government regulation of, or involvement in, the pricing and/or purchasing of drugs.
    - Restricting the Company's ability to limit providers' participation in its networks and/or remove providers from its networks by imposing network adequacy requirements or otherwise (including in its Medicare and Commercial Health Care Benefits products).
    - Imposing assessments on (or to be collected by) health plans or health carriers that may or may not be passed through to their customers. These assessments may include assessments for insolvency, the uninsured, uncompensated care, Medicaid funding or defraying health care provider medical malpractice insurance costs.
    - Mandating coverage by the Company's and its clients' health plans for additional conditions and/or specified procedures, drugs or devices (e.g., high cost pharmaceuticals, experimental pharmaceuticals and oral chemotherapy regimens).
    - Regulating electronic connectivity.
    - Mandating or regulating the disclosure of provider fee schedules, manufacturer's rebates and other data about the Company's payments to providers and/or payments the Company receives from pharmaceutical manufacturers.
    - Mandating or regulating disclosure of provider outcome and/or efficiency information.
    - Prescribing or limiting members' financial responsibility for health care or other covered services they utilize, including restricting "surprise" bills by providers and by specifying procedures for resolving "surprise" bills.

- Prescribing payment levels for health care and other covered services rendered to the Company's members by providers who do not have contracts with the Company.
- Assessing the medical device status of home infusion therapy products and/or solutions, mobile consumer wellness tools and clinical decision support tools, which may require compliance with FDA requirements in relation to some of these products, solutions and/or tools.
- Restricting the ability of employers and/or health plans to establish or impose member financial responsibility.
- Proposals to expand benefits under Original Medicare.
- Amending or supplementing ERISA to impose greater requirements on PBMs or the administration of employer-funded benefit plans or limit the scope of current ERISA pre-emption, which would among other things expose

the Company and other health plans to expanded liability for punitive and other extra-contractual damages and additional state regulation.

It is uncertain whether the Company can counter the potential adverse effects of such potential legislation or regulation on its operating results or cash flows, including whether it can recoup, through higher premium rates, expanded membership or other measures, the increased costs of mandated coverage or benefits, assessments, fees, taxes or other increased costs, including the cost of modifying its systems to implement any enacted legislation or regulations.

The Company's businesses also may be affected by other legislation and regulations. The Dodd-Frank Wall Street Reform and Consumer Protection Act creates incentives for whistleblowers to speak directly to the government rather than utilizing internal compliance programs and reduces the burden of proof under the Foreign Corrupt Practices Act of 1977 (the "FCPA"). There also are laws and regulations that set standards for the escheatment of funds to states.

Health savings accounts, health reimbursement arrangements and flexible spending accounts and certain of the tax, fee and subsidy provisions of the ACA also are regulated by the U.S. Department of the Treasury and the Internal Revenue Service.

The Company also may be adversely affected by court and regulatory decisions that expand or revise the interpretations of existing statutes and regulations or impose medical malpractice or bad faith liability. Federal and state courts, including the U.S. Supreme Court, continue to consider cases, and federal and state regulators continue to issue regulations and interpretations, addressing bad faith liability for denial of medical claims, the scope of ERISA's fiduciary duty requirements, the scope of the False Claims Act and the pre-emptive effect of ERISA and Medicare Part D on state laws.

Contract Audits - The Company is subject to audits of many of its contracts, including its PBM client contracts, its PBM rebate contracts, its PBM network contracts, its contracts relating to Medicare Advantage and/or Medicare Part D, the agreements the Company's pharmacies enter into with other payors, its Medicaid contracts and its customer contracts. Because some of the Company's contracts are with state or federal governments or with entities contracted with state or federal agencies, audits of these contracts are often regulated by the federal or state agencies responsible for administering federal or state benefits programs, including those which operate Medicaid fee for service plans, Managed Medicaid plans, Medicare Part D plans or Medicare Advantage organizations.

Federal Employee Health Benefits Program - The Company's subsidiaries contract with the Office of Personnel Management (the "OPM") to provide managed health care services under the FEHB program in their service areas. These contracts with the OPM and applicable government regulations establish premium rating arrangements for this program. In addition to other requirements, such as the Transparency in Coverage Rule note above, OPM regulations require that community-rated FEHB plans meet a FEHB program-specific minimum MLR by plan code and market. Managing to these rules is complicated by the simultaneous application of the minimum MLR standards and associated premium rebate requirements of the ACA. The Company also has a contractual arrangement with carriers for the FEHB program, such as the BlueCross BlueShield Association, to provide pharmacy services to federal employees, postal workers, annuitants, and their dependents under the Government-wide Service Benefit Plan, as authorized by the FEHB Act and as part of the FEHB program. Additionally, the Company manages certain FEHB plans on a "cost-plus" basis. These arrangements subject the Company to certain aspects of the FEHB Act, and other federal regulations, such as the FEHB Acquisition Regulation, that otherwise would not be applicable to the Company. The OPM also is auditing the Company and its other contractors to, among other things, verify that plans meet their applicable FEHB program-specific MLR and the premiums established under the OPM's Insured contracts and costs allocated pursuant to the OPM's cost-based contracts are in compliance with the requirements of the applicable FEHB program. The OPM may seek premium refunds or institute other sanctions against the Company if it fails to comply with the FEHB program requirements.

Clinical Services Regulation - The Company provides clinical services to health plans, PBMs and providers for a variety of complex and common medical conditions, including arranging for certain members to participate in disease management programs. State laws regulate the practice of medicine, the practice of pharmacy, the practice of nursing and certain other clinical activities. Clinicians engaged in a professional practice in connection with the

provision of clinical services must satisfy applicable state licensing requirements and must act within their scope of practice.

Third Party Administration and Other State Licensure Laws - Many states have licensure or registration laws governing certain types of administrative organizations, such as PPOs, TPAs and companies that provide utilization review services. Several states also have licensure or registration laws governing the organizations that provide or administer consumer card programs (also known as cash card or discount card programs).

International Regulation - The Company has insurance licenses in several foreign jurisdictions and does business directly or through local affiliations in numerous countries around the world. The Company has taken steps to be able to continue to serve customers in the European Economic Area following the United Kingdom's exit from the EU ("Brexit").

The Company's international operations are subject to different, and sometimes more stringent, legal and regulatory requirements, which vary widely by jurisdiction, including anti-corruption laws; economic sanctions laws; various privacy, insurance, tax, tariff and trade laws and regulations; corporate governance, privacy, data protection (including the EU's General Data Protection Regulation which began to apply across the EU during 2018), data mining, data transfer, labor and employment, intellectual property, consumer protection and investment laws and regulations; discriminatory licensing procedures; compulsory cessions of reinsurance; required localization of records and funds; higher premium and income taxes; limitations on dividends and repatriation of capital; and requirements for local participation in an insurer's ownership. In addition, the expansion of the Company's operations into foreign countries increases the Company's exposure to the anti-bribery, anti-corruption and anti-money laundering provisions of U.S. law, including the FCPA, and corresponding foreign laws, including the U.K. Bribery Act 2010 (the "UK Bribery Act").

Anti-Corruption Laws - The FCPA prohibits offering, promising or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. The Company also is subject to applicable anti-corruption laws of the jurisdictions in which it operates. In many countries outside the United States, health care professionals are employed by the government. Therefore, the Company's dealings with them are subject to regulation under the FCPA. Violations of the FCPA and other anti-corruption laws may result in severe criminal and civil sanctions as well as other penalties, and there continues to be a heightened level of FCPA enforcement activity by the U.S. Securities and Exchange Commission (the "SEC") and the DOJ. The UK Bribery Act is an anti-corruption law that is broader in scope than the FCPA and applies to all companies with a nexus to the United Kingdom. Disclosures of FCPA violations may be shared with the UK authorities, thus potentially exposing companies to liability and potential penalties in multiple jurisdictions.

Anti-Money Laundering Regulations - Certain lines of the Company's businesses are subject to Treasury anti-money laundering regulations. Those lines of business have implemented anti-money laundering policies designed to ensure their compliance with the regulations. The Company also is subject to anti-money laundering laws in non-U.S. jurisdictions where it operates.

Office of Foreign Assets Control - The Company also is subject to regulation by the Office of Foreign Assets Control of the U.S. Department of Treasury ("OFAC"). OFAC administers and enforces economic and trade sanctions based on U.S. foreign policy and national security goals against targeted foreign countries and regimes, terrorists, international narcotics traffickers, those engaged in activities related to the proliferation of weapons of mass destruction, and other threats to the national security, foreign policy or economy of the United States. In addition, the Company is subject to similar regulations in the non-U.S. jurisdictions in which it operates.

FDA Regulation - The FDA regulates the Company's compounding pharmacy and clinical research operations. The FDA also generally has authority to, among other things, regulate the manufacture, distribution, sale and labeling of medical devices (including hemodialysis devices such as the device the Company is developing and mobile medical devices) and many products sold through retail pharmacies, including prescription drugs, over-the-counter medications, cosmetics, dietary supplements and certain food items. In addition, the FDA regulates the Company's activities as a distributor of store brand products.

Laws and Regulations Related to the Health Care Benefits Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state, local and international statutes and regulations governing its Health Care Benefits segment specifically.

Overview - Differing approaches to state insurance regulation and varying enforcement philosophies may materially and adversely affect the Company's ability to standardize its Health Care Benefits products and services across state lines. These laws and regulations, including the ACA, restrict how the Company conducts its business and result in additional burdens and costs to the Company. Significant areas of governmental regulation include premium rates

and rating methodologies, underwriting rules and procedures, required benefits, sales and marketing activities, provider rates of payment, restrictions on health plans' ability to limit providers' participation in their networks and/or remove providers from their networks and financial condition (including reserves and minimum capital or risk based capital requirements). These laws and regulations are different in each jurisdiction and vary from product to product.

Each health insurer and HMO must file periodic financial and operating reports with the states in which it does business. In addition, health insurers and HMOs are subject to state examination and periodic license renewal. Applicable laws also restrict the ability of the Company's regulated subsidiaries to pay dividends, and certain dividends require prior regulatory approval. In addition, some of the Company's businesses and related activities may be subject to PPO, MCO, utilization review or TPA-related licensure requirements and regulations. These licensure requirements and regulations differ from state to state, but may contain provider network, contracting, product and rate, financial and reporting requirements. There also are laws and regulations that set specific standards for the Company's delivery of services, payment of claims, fraud prevention, protection of consumer health information, and payment for covered benefits and services.

Required Regulatory Approvals - The Company must obtain and maintain regulatory approvals to price, market and administer many of its Health Care Benefits products. Supervisory agencies, including CMS, the Center for Consumer Information and Insurance Oversight and the DOL, as well as state health, insurance, managed care and Medicaid agencies, have broad authority to take one or more of the following actions:

- Grant, suspend and revoke the Company's licenses to transact business;
- Suspend or exclude the Company from participation in government programs;
- Suspend or limit the Company's authority to market products;
- Regulate many aspects of the products and services the Company offers, including the pricing and underwriting of many of its products and services;
- Assess damages, fines and/or penalties;
- Terminate the Company's contract with the government agency and/or withhold payments from the government agency to the Company;
- Impose retroactive adjustments to premiums and require the Company to pay refunds to the government, customers and/or members;
- Restrict the Company's ability to conduct acquisitions or dispositions;
- Require the Company to maintain minimum capital levels in its subsidiaries and monitor its solvency and reserve adequacy;
- Regulate the Company's investment activities on the basis of quality, diversification and other quantitative criteria; and/or
- Exclude the Company's plans from participating in Public Exchanges if they are deemed to have a history of "unreasonable" premium rate increases or fail to meet other criteria set by HHS or the applicable state.

The Company's operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time the Company receives subpoenas and other requests for information from, federal, state and international supervisory and enforcement agencies, attorneys general and other state, federal and international governmental authorities and legislators.

Commercial Product Pricing and Underwriting Restrictions - Pricing and underwriting regulation by states limits the Company's underwriting and rating practices and those of other health insurers, particularly for small employer groups, and varies by state. In general, these limitations apply to certain customer segments and limit the Company's ability to set prices for new or renewing groups, or both, based on specific characteristics of the group or the group's prior claim experience. In some states, these laws and regulations restrict the Company's ability to price for the risk it assumes and/or reflect reasonable costs in the Company's pricing.

The ACA expanded the premium rate review process by, among other things, requiring the Company's Commercial Insured rates to be reviewed for "reasonableness" at either the state or the federal level. HHS established a federal premium rate review process that generally applies to proposed premium rate increases equal to or exceeding a federally (or lower state) specified threshold. HHS's rate review process imposes additional public disclosure requirements as well as additional review on filings requesting premium rate increases equal to or exceeding this "reasonableness" threshold. These combined state and federal review requirements may prevent, further delay or otherwise affect the Company's ability to price for the risk it assumes, which could adversely affect its MBRs and

operating results, particularly during periods of increased utilization of medical services and/or medical cost trend or when such utilization and/or trend exceeds the Company's projections.

The ACA also specifies minimum MLRs of 85% for large group Commercial products and 80% for individual and small group Commercial products. Because the ACA minimum MLRs are structured as "floors" for many of their requirements, states have the latitude to enact more stringent rules governing these restrictions. For Commercial products, states have and may adopt higher minimum MLR requirements, use more stringent definitions of "medical loss ratio," incorporate minimum MLR

requirements into prospective premium rate filings, require prior approval of premium rates or impose other requirements related to minimum MLR. Minimum MLR requirements and similar actions further limit the level of margin the Company can earn in its Insured Commercial products while leaving the Company exposed to medical costs that are higher than those reflected in its pricing. The Company also may be subject to significant fines, penalties, premium refunds and litigation if it fails to comply with minimum MLR laws and regulations.

In addition, the Company requested increases in its premium rates in its Commercial Health Care Benefits business for 2022 and expects to continue to request increases in those rates for 2023 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and rating limits, and significant assessments, fees and taxes imposed by the federal and state governments, including as a result of the ACA. The Company's rates also must be adequate to reflect adverse selection in its products, particularly in small group Commercial products. These rate increases may be significant and thus heighten the risks of adverse publicity, adverse regulatory action and adverse selection and the likelihood that the Company's requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

Many of the laws and regulations governing the Company's pricing and underwriting practices also limit the differentials in premium rates insurers and other carriers may charge between new and renewal business, and/or between groups based on differing characteristics. They may also require that carriers disclose to customers the basis on which the carrier establishes new business and renewal premium rates and limit the ability of a carrier to terminate customers' coverage.

Recently, with respect to quality improvement activities ("QIAs") that health plans report to HHS, revised regulations no longer provide insurers the option of reporting a flat amount equal to 0.8 percent of earned premium in lieu of reporting the insurers' actual itemized QIA expenditures. This change will impact the Company's future MLR calculations and reporting since we have utilized the 0.8 percent premium election.

Medicaid Regulation - The Company is seeking to substantially grow its Medicaid, dual eligible and dual eligible special needs plan businesses over the next several years. As a result, the Company also is increasing its exposure to changes in government policy with respect to and/or regulation of the various Medicaid, dual eligible and dual eligible special needs plan programs in which the Company participates, including changes in the amounts payable to the Company under those programs.

Since 2017, Managed Medicaid products, including those the Company offers, are subject to a minimum federal MLR of 85%. A Medicaid managed care quality rating system and provider network adequacy requirements also apply to Medicaid products. Because the federal minimum MLR is structured as a "floor," states have the latitude to enact more stringent rules governing these restrictions. For Managed Medicaid products, states may adopt higher minimum MLR requirements, use more stringent definitions of "medical loss ratio" or impose other requirements related to minimum MLR. Minimum MLR requirements and similar actions further limit the level of margin the Company can earn in its Insured Medicaid products while leaving the Company exposed to medical costs that are higher than those reflected in its pricing. The Company also may be subject to significant fines, penalties, premium refunds and litigation if it fails to comply with minimum MLR laws and regulations.

States continue to consider Medicaid expansion; however, 12 states have still not decided to expand as of 2022. States may opt out of the elements of the ACA requiring expansion of Medicaid coverage without losing their current federal Medicaid funding. In addition, the election of new governors and/or state legislatures may impact states' previous decisions regarding Medicaid expansion. Although Congress enacted incentives for states that had not yet done so to expand Medicaid, this incentive alone may not persuade holdout states to expand.

In 2021, Medicaid MCOs faced new requirements and state flexibility that were finalized in the 2020 Medicaid managed care final rule. States now have flexibility related to rate setting and provider network adequacy that could adversely or positively impact our Medicaid plans. Other changes related to managed care operations include beneficiary communications, appeals and grievances, and provider directories.

The economic aspects of the Medicaid, dual eligible and dual eligible special needs plan business vary from state to state and are subject to frequent change. Medicaid premiums are paid by each state and differ from state to state. The federal government and certain states also are considering proposals and legislation for Medicaid and dual eligible program reforms or redesigns, including restrictions on the collection of manufacturer's rebates on pharmaceuticals

by Medicaid MCOs and their contracted PBMs, further program, population and/or geographic expansions of risk-based managed care, increasing beneficiary cost-sharing or payment levels, and changes to benefits, reimbursement, eligibility criteria, provider network adequacy requirements (including requiring the inclusion of specified high cost providers in the Company's networks) and program structure. In some states, current Medicaid and dual eligible funding and premium revenue may not be adequate for the Company to continue

program participation. The Company's Medicaid and dual eligible contracts with states (or sponsors of Medicaid managed care plans) are subject to cancellation by the state (or the sponsors of the managed care plans) after a short notice period without cause (e.g., when a state discontinues a managed care program) or in the event of insufficient state funding.

The Company's Medicaid, dual eligible and dual eligible special needs plan products also are heavily regulated by CMS and state Medicaid agencies, which have the right to audit the Company's performance to determine compliance with CMS contracts and regulations. The Company's Medicaid products, dual eligible products and CHIP contracts also are subject to complex federal and state regulations and oversight by state Medicaid agencies regarding the services provided to Medicaid enrollees, payment for those services, network requirements (including mandatory inclusion of specified high-cost providers), and other aspects of these programs, and by external review organizations which audit Medicaid plans on behalf of state Medicaid agencies. The laws, regulations and contractual requirements applicable to the Company and other participants in Medicaid and dual eligible programs, including requirements that the Company submit encounter data to the applicable state agency, are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and its Medicaid and dual eligible program compliance efforts will continue to require significant resources. CMS and/or state Medicaid agencies may fine the Company, withhold payments to the Company, seek premium and other refunds, terminate the Company's existing contracts, elect not to award the Company new contracts or not to renew the Company's existing contracts, prohibit the Company from continuing to market and/or enroll members in or refuse to automatically assign members to one or more of the Company's Medicaid or dual eligible products, exclude the Company from participating in one or more Medicaid or dual eligible programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS or state regulations or contractual requirements.

The Company cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid program, nor can it predict the impact those changes will have on its business operations or operating results, but the effects could be materially adverse.

Federal and State Reporting - The Company is subject to extensive financial and business reporting requirements, including penalties for inaccuracies and/or omissions, at both the federal and state level. The Company's ability to comply with certain of these requirements depends on receipt of information from third parties that may not be readily available or reliably provided in all instances. The Company is and will continue to be required to modify its information systems, dedicate significant resources and incur significant expenses to comply with these requirements. However, the Company cannot eliminate the risks of unavailability of or errors in its reports.

Product Design and Administration and Sales Practices - State and/or federal regulatory scrutiny of health care benefit product design and administration and marketing and advertising practices, including the filing of insurance policy forms, the adequacy of provider networks, the accuracy of provider directories, and the adequacy of disclosure regarding products and their administration, is increasing as are the penalties being imposed for inappropriate practices. Medicare, Medicaid and dual eligible products and products offering more limited benefits in particular continue to attract increased regulatory scrutiny.

Guaranty Fund Assessments/Solvency Protection - Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer governed health plans established under the ACA. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that limit future offsets.

Laws and Regulations Related to the Pharmacy Services Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state and local statutes and regulations governing the operation of its Pharmacy Services segment specifically. Among these are the following:

PBM Laws and Regulation - Legislation and/or regulations seeking to regulate PBM activities in a comprehensive manner have been proposed or enacted in a number of states. This legislation could adversely affect the Company's ability to conduct business on commercially reasonable terms in states where the legislation is in effect and the Company's ability to standardize

its PBM products and services across state lines. In addition, certain quasi-regulatory organizations, including the National Association of Boards of Pharmacy and the NAIC and the National Council of Insurance Legislators, have issued model regulations or may propose future regulations concerning PBMs and/or PBM activities. Similarly, credentialing organizations such as URAC have established voluntary standards regarding PBM, mail order pharmacy and/or specialty pharmacy activities. While the actions of these quasi-regulatory or standard-setting organizations do not have the force of law, they may influence states to adopt their requirements or recommendations and influence client requirements for PBM, mail order pharmacy and/or specialty pharmacy services. Moreover, any standards established by these organizations could also impact the Company's health plan clients and/or the services provided to those clients and/or the Company's health plans.

The Company's PBM activities also are regulated directly and indirectly at the federal and state levels, including being subject to the False Claims Act and state false claims acts and the AKS and state anti-kickback laws. These laws and regulations govern, and proposed legislation and regulations may govern and/or further restrict, critical PBM practices, including disclosure, receipt and retention of rebates and other payments received from pharmaceutical manufacturers; use of, administration of and/or changes to drug formularies, maximum allowable cost ("MAC") list pricing, average wholesale prices ("AWP") and/or clinical programs; the offering to plan sponsors of pricing that includes retail network "differential" or "spread" (i.e., a difference between the drug price charged to the plan sponsor by a PBM and the price paid by the PBM to the dispensing provider); reconciliation to pricing guarantees; disclosure of data to third parties; drug UM practices; the level of duty a PBM owes its customers; configuration of pharmacy networks; the operations of the Company's pharmacies (including audits of its pharmacies); disclosure of negotiated provider reimbursement rates; disclosure of fees associated with administrative service agreements and patient care programs that are attributable to members' drug utilization; and registration or licensing of PBMs. Failure by the Company or one of its PBM services suppliers to comply with these laws or regulations could result in material fines and/or sanctions and could have a material adverse effect on the Company's operating results and/or cash flows.

The Company's PBM service contracts, including those in which the Company assumes certain risks under performance guarantees or similar arrangements, are generally not subject to insurance regulation by the states. However, state departments of insurance are increasing their oversight of PBM activities due to legislation passing in a number of states requiring PBMs to register or obtain a license with the department, including through market conduct examinations and other audits our licensed entities. In addition, rulemaking is either underway or has already taken place in a number of states with the areas of focus on licensure requirements, pharmacy reimbursement for generics (MAC reimbursement) and pharmacy audits - most of which fall under the state insurance code.

Most-Favored-Nation Rule - In November 2020, HHS released the Most-Favored-Nation Rule (the "MFN Rule"), which requires CMS to take a most-favored-nation approach in calculating payment for Medicare Part B drugs. The MFN Rule will test paying Part B drugs at comparable amounts to the lowest adjusted price paid by any country in the Organization for Economic Co-operation and Development that has a Gross Domestic Product ("GDP") per capita that is at least 60% of the U.S. GDP per capita. The MFN Rule will also test a redesign of the percentage add-on payment structure under Medicare Part B to remove incentives for use of higher-cost drugs through a flat per-dose add-on payment, and will include a financial hardship exemption for participants. The mandatory MFN Rule will operate for seven years, from January 1, 2021 to December 31, 2027. Over the course of the model, CMS will monitor and evaluate the impact of the MFN Rule on beneficiary access to drugs, program costs, and the quality of care for beneficiaries. Further, CMS commits to assess initial impacts of the MFN Rule on quality of care, including access to drugs, prior to beginning performance year 5. Multiple pharmaceutical manufacturers have sued HHS over the rule, and it is currently delayed due to a temporary restraining order prohibiting CMS from implementing it. If implemented, the MFN Rule may impact the ability of the Company to negotiate drug prices and provide competitive products and services to consumers. In August 2021, CMS published a proposed rule to rescind the MFN Rule. It is unclear whether this rescission may be followed by regulatory or legislative alternatives that present similar, or even more substantial, patient access, provider reimbursement, and other concerns.

Pharmacy Network Access Legislation - Medicare Part D and a majority of states now have some form of legislation affecting the Company's (and its health plans' and its health plan clients') ability to limit access to a pharmacy provider network or remove pharmacy network providers. For example, certain "any willing provider" legislation may require the Company or its clients to admit a nonparticipating pharmacy if such pharmacy is willing and able to meet the plan's price and other applicable terms and conditions for network participation. These laws could negatively affect the services and economic benefits achievable through a limited pharmacy provider network.

Also, a majority of states now have some form of legislation affecting the Company's ability (and the Company's and its client health plans' ability) to conduct audits of network pharmacies regarding claims submitted to the Company for payment. These laws could negatively affect the Company's ability to recover overpayments of claims submitted by network pharmacies that the Company identifies through pharmacy audits.

Finally, several states have passed legislation that limits the ability of PBMs and health insurers to provide special benefit structures for use with affiliated pharmacies, which could result in reduced savings to clients and consumers.

Pharmacy Pricing Legislation - A number of states have passed legislation regulating the Company's ability to manage and establish MACs for generic prescription drugs. MAC methodology is a common cost management practice used by private and public payors (including CMS) to pay pharmacies for dispensing generic prescription drugs. MAC prices specify the allowable reimbursement by a PBM for a particular strength and dosage of a generic drug that is available from multiple manufacturers but sold at different prices. State legislation can regulate the disclosure of MAC prices and MAC price methodologies, the kinds of drugs that a PBM can pay for at a MAC price, and the rights of pharmacies to appeal a MAC price established by a PBM. These laws could negatively affect the Company's ability to establish MAC prices for generic drugs. Additionally, some states have passed legislation that would create a reimbursement benchmark mandate, such as the national average drug acquisition cost and/or the wholesale acquisition cost ("WAC"), plus a set dispensing fee, for pharmacies in the network.

Formulary and Plan Design Regulation - A number of government entities regulate the administration of prescription drug benefits. HHS regulates how Medicare Part D formularies are developed and administered, including requiring the inclusion of all drugs in certain classes and categories, subject to limited exceptions. Under the ACA, CMS imposes drug coverage requirements for health plans required to cover essential health benefits, including plans offered through federal or state Public Exchanges. Additionally, the NAIC and health care accreditation agencies like NCQA and URAC have developed model acts and standards for formulary development that are often incorporated into government requirements. Many states regulate the scope of prescription drug coverage, as well as the delivery channels to receive prescriptions, for insurers, MCOs and Medicaid managed care plans. The increasing government regulation of formularies could significantly affect the Company's ability to develop and administer formularies, pharmacy networks and other plan design features. Similarly, some states prohibit health plan sponsors from implementing certain restrictive pharmacy benefit plan design features. This regulation could limit or preclude (i) limited networks, (ii) a requirement to use particular providers, (iii) copayment differentials among providers and (iv) formulary tiering practices.

Laws and Regulations Related to the Retail/LTC Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state and local statutes and regulations governing the operation of its Retail/LTC segment specifically. Among these are the following:

Retail Medical Clinics - States regulate retail medical clinics operated by nurse practitioners or physician assistants through physician oversight, clinic and lab licensure requirements and the prohibition of the corporate practice of medicine. A number of states have implemented or proposed laws or regulations that impact certain components of retail medical clinic operations such as physician oversight, signage, third party contracting requirements, bathroom facilities, and scope of services. These laws and regulations may affect the operation and expansion of the Company's owned and managed retail medical clinics.

Other Laws - Other federal, state and local laws and regulations also impact the Company's retail operations, including laws and regulations governing the practice of optometry, the practice of audiology, the provision of dietician services and the sale of durable medical equipment, contact lenses, eyeglasses, hearing aids and alcohol.

Available Information

CVS Health Corporation was incorporated in Delaware in 1996. The corporate office is located at One CVS Drive, Woonsocket, Rhode Island 02895, telephone (401) 765-1500. CVS Health Corporation's common stock is listed on the New York Stock Exchange under the trading symbol "CVS." General information about the Company is available through the Company's website at *http://www.cvshealth.com*. The Company's financial press releases and filings with the SEC are available free of charge within the Investors section of the Company's website at *http://investors.cvshealth.com*. In addition, the SEC maintains an internet site that contains reports, proxy and information statements and other information regarding issuers, such as the Company, that file electronically with the SEC. The address of that website is *http://www.sec.gov.* The information on or linked to the Company's website is neither a part of nor incorporated by reference in this 10-K or any of the Company's other SEC filings.

In accordance with guidance provided by the SEC regarding use by a company of its websites and social media channels as a means to disclose material information to investors and to comply with its disclosure obligations under SEC Regulation FD, CVS Health Corporation (the "Registrant") hereby notifies investors, the media and other interested parties that it intends to continue to use its media and investor relations website (*http://investors.cvshealth.com/*) and its Twitter feed (@CVSHealthIR)

to publish important information about the Registrant, including information that may be deemed material to investors. The list of social media channels that the Registrant uses may be updated on its media and investor relations website from time to time. The Registrant encourages investors, the media, and other interested parties to review the information the Registrant posts on its website and social media channels as described above, in addition to information announced by the Registrant through its SEC filings, press releases and public conference calls and webcasts.

Item 1A. Risk Factors.

You should carefully consider each of the following risks and uncertainties and all of the other information set forth in this 10-K. These risks and uncertainties and other factors may affect forward-looking statements, including those we make in this 10-K or elsewhere, such as in news releases or investor or analyst calls, meetings or presentations, on our websites or through our social media channels. The risks and uncertainties described below are not the only ones we face. There can be no assurance that we have identified all the risks that affect us. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial also may adversely affect our businesses. Any of these risks or uncertainties could cause our actual results to differ materially from our expectations and the expected results discussed in our forward-looking statements. You should not consider past results to be an indication of future performance.

If any of the following risks or uncertainties develops into actual events or if the circumstances described in the risks or uncertainties occur or continue to occur, those events or circumstances could have a material adverse effect on our businesses, operating results, cash flows, financial condition and/or stock price, among other effects on us. You should read the following section in conjunction with the MD&A, included in Item 7 of this 10-K, our consolidated financial statements and the related notes, included in Item 8 of this 10-K, and our “Cautionary Statement Concerning Forward-Looking Statements” in this 10-K.

Summary

The following is a summary of the principal risks we face that could negatively impact our businesses, operating results, cash flows and/or financial condition:

Risks Relating to Our Businesses

- The impact COVID-19 will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be material and adverse.
- We may not be able to accurately forecast health care and other benefit costs.
- Adverse economic conditions in the U.S. and abroad can materially and adversely impact our businesses, operating results, cash flows and financial condition.
- Each of our segments operates in a highly competitive and evolving business environment.
- A change in our Health Care Benefits product mix may adversely affect our profit margins.
- We can provide no assurance that we will be able to compete successfully and profitably on Public Exchanges.
- Negative public perception of the industries in which we operate can adversely affect our businesses, operating results, cash flows and prospects.
- We must maintain and improve our relationships with our customers and increase the demand for our products and services.
- We face risks relating to the availability, pricing and safety profiles of prescription drugs that we purchase and sell.
- The reserves we hold for expected claims in our Insured Health Care Benefits products are based on estimates that involve an extensive degree of judgment and are inherently variable, and any reserve, including a premium deficiency reserve, may be insufficient.
- We are exposed to risks relating to the solvency of other insurers.

Risks From Changes in Public Policy and Other Legal and Regulatory Risks

- We are subject to potential changes in public policy, laws and regulations, including reform of the U.S. health care system and entitlement programs.

- If we fail to comply with applicable laws and regulations we could be subject to significant adverse regulatory actions.
- If our compliance or other systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions and/or litigation.

- We routinely are subject to litigation and other adverse legal proceedings, including class actions and *qui tam* actions. Many of these proceedings seek substantial damages which may not be covered by insurance.
- We frequently are subject to regular and special governmental audits, investigations and reviews that could result in changes to our business practices and also could result in material refunds, fines, penalties, civil liabilities, criminal liabilities and other sanctions.
- Our litigation and regulatory risk profiles are changing as we offer new products and services and expand in business areas beyond our historical core businesses.
- We face unique regulatory and other challenges in our Medicare and Medicaid businesses.
- Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues.
- We may not be able to obtain adequate premium rate increases in our Insured Health Care Benefits products, MBRs and operating results and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes.
- Minimum MLR rebate requirements limit the level of margin we can earn in our Insured Health Care Benefits products while leaving us exposed to higher than expected medical costs. Challenges to our minimum MLR rebate methodology and/or reports could adversely affect our operating results.
- Our operating results may be adversely affected by changes in laws and policies governing employers and by union organizing activity.

Risks Associated with Mergers, Acquisitions, and Divestitures

- We may be unable to successfully integrate companies we acquire.
- We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities, which may be unsuccessful, cause us to assume unanticipated liabilities, disrupt our existing businesses, be dilutive or lead us to assume significant debt, among other things.

Risks Related to Our Operations

- Failure to meet customer and investor expectations, including with respect to environmental, social and governance goals, may harm our brand and reputation, our ability to retain and grow our customer base and membership.
- We and our vendors have experienced and continue to experience information security incidents. We can provide no assurance that we or our vendors will be able to contain detect or prevent incident.
- Data governance failures or the failure or disruption of our information technology or infrastructure can adversely affect our reputation, businesses and prospects. Our use and disclosure of members', customers' and other constituents' sensitive information is subject to complex regulations at multiple levels.
- Product liability, product recall or personal injury issues could damage our reputation.
- We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success.
- Sales of our products and services are dependent on our ability to attract and motivate internal sales personnel and independent third-party brokers, consultants and agents. We may be subject to penalties or other regulatory actions as a result of the marketing practices of brokers and agents selling our products.
- Failure of our businesses to effectively collaborate could prevent us from maximizing our operating results.
- Pursuing multiple information technology improvement initiatives simultaneously could make continued development and implementation significantly more challenging.
- We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.
- Both our and our vendors' operations are subject to a variety of business continuity hazards and risks that could interrupt our operations or otherwise adversely affect our performance and operating results.

Financial Risks

- We would be adversely affected by downgrades or potential downgrades in our credit ratings, should they occur, or if we do not effectively deploy our capital.
- Goodwill and other intangible assets could, in the future, become impaired.

- Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative instruments and other investments.

Risks Related to Our Relationships with Manufacturers, Providers, Suppliers and Vendors

- We face risks relating to the market availability, pricing, suppliers and safety profiles of prescription drugs and other products that we purchase and sell.
- We need to be able to maintain our ability to contract with providers on competitive terms and develop and maintain attractive networks with high quality providers.
- If our suppliers or service providers fail to meet their contractual obligations to us or to comply with applicable laws or regulations, we may be exposed to brand and reputational harm, litigation and/or regulatory action.
- We may experience increased medical and other benefit costs, litigation risk and customer and member dissatisfaction when providers that do not have contracts with us render services to our Health Care Benefits members.
- Continuing consolidation and integration among providers and other suppliers may increase our costs and increase competition.

Risks Related to COVID-19

The spread of, impact of and response to COVID-19 underscores and amplifies certain risks we face. The impact COVID-19 will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be material and adverse.

COVID-19 has spread to every state in the U.S., has been declared a pandemic by the World Health Organization and has severely impacted, and is expected to continue to severely impact, the economies of the U.S. and other countries around the world.

The legislative and regulatory environment governing our businesses is dynamic and changing frequently, including the Families First Act, the CARES Act, the American Rescue Plan Act and mandated increases to the medical services we must pay for without a corresponding increase in the premiums we receive in our Health Care Benefits Insured products. As a result of COVID-19, including legislative and/or regulatory responses to COVID-19, the premiums we charge in our Insured Health Care Benefits products may prove to be insufficient to cover the cost of medical services delivered to our Insured medical members, which may increase significantly as a result of higher utilization rates of medical facilities and services and other increases in associated hospital and pharmaceutical costs.

Federal, state and local governmental policies and initiatives to reduce the transmission of COVID-19, including existing and new variants, such as mask and vaccination mandates, restrictions on large gatherings and social distancing directives, may not effectively combat the severity and/or duration of the COVID-19 pandemic and have resulted in, among other things, a reduction in utilization that is discretionary, the cancellation of elective medical procedures, reduced customer traffic and front store sales in our retail pharmacies, our customers being ordered to close or severely curtail their operations, the adoption of work-from-home policies and a reduction in diagnostic reporting due to reductions in health care provider visits and restrictions on our access to providers' medical records, all of which impact our businesses. Among other impacts of these policies and initiatives on our businesses, there may be changes in medical claims submission patterns and an adverse impact on (i) drug utilization due to the reduction in discretionary visits with providers; (ii) front store sales as a result of reduced customer traffic in our retail pharmacies; (iii) medical membership in our Health Care Benefits segment and covered lives in our PBM clients due to reductions in workforce at our existing customers (including due to business failures) as well as reduced willingness to change benefits providers by prospective customers; (iv) benefit costs due to COVID-19 related support programs we have put in place for our medical members and mandated increases to the medical services we must pay for without a corresponding increase in the premiums we receive in our Insured Health Care Benefits products; and (v) the amount, timing and collectability of payments to the Company from customers, clients, government payers and members as a result of the impact of COVID-19 on them. Over time, these policies and initiatives also may cause us to experience increased benefit costs and/or decreased revenues in our Health Care Benefits segment if, as a result of our medical members not seeing their providers as a result of COVID-19, we are unable to implement clinical initiatives to manage benefit costs and chronic conditions of our medical members and appropriately document their risk profiles.

In addition, in response to COVID-19, during the first half of 2020, we began to offer our medical members expanded benefit coverage and became obligated by governmental action to provide other additional coverage. This expanded benefit coverage continued to be provided without a corresponding increase in the premiums we receive in our Insured Health Care Benefits

products. We also are taking actions designed to help provide financial and administrative relief for the health care provider community. Such measures and any further steps we take or are required to take to expand or otherwise modify the services delivered to our Health Care Benefits members, provide relief for the health care provider community, or in connection with the relaxation of social distancing directives and other restrictions on movement and economic activity intended to reduce the spread of COVID-19, including the potential for widespread testing and vaccination, including boosters, as a component of lifting those measures, could adversely impact our benefit costs, MBR and operating results.

The various initiatives we have implemented to slow and/or reduce the impact of COVID-19 and the COVID-19-related support programs we have put in place for our customers, medical members and colleagues have increased our operating expenses and reduced the efficiency of our operations. Our operating results will continue to be adversely affected so long as these initiatives continue or if they are expanded. In addition, any adverse economic conditions that could be caused by COVID-19 may have an adverse impact on our net investment income and the value of our investment portfolio.

The spread of COVID-19, or actions taken to mitigate its spread, could have material and adverse effects on our ability to operate our businesses effectively, including as a result of the complete or partial closure of facilities, labor shortages and/or financial difficulties experienced by third-party service providers. Disruptions in our supply chains, our distribution chains and/or public and private infrastructure, including those caused by industry capacity constraints, material availability, global logistics delays and constraints arising from, among other things, the transportation capacity of ocean shipping containers, and labor availability constraints, could materially and adversely impact our business operations. We have transitioned a significant subset of our colleagues to a remote work environment in an effort to mitigate the spread of COVID-19, as have a significant number of our third-party service providers, which may amplify certain risks to our businesses, including an increased demand for information technology resources, increased risk of phishing and other cybersecurity attacks, increased risk of unauthorized dissemination of sensitive personal information or proprietary or confidential information about us or our medical members or other third-parties and increased risk of business interruptions.

The COVID-19 pandemic continues to evolve and the severity and duration of the pandemic and scope and intensity of the governmental response to it are unknown at this time. We believe COVID-19's impact on our businesses, operating results, cash flows and/or financial condition primarily will be driven by the geographies impacted and the severity and duration of the pandemic; vaccination rates; the severity of any new COVID-19 variants and whether vaccines are effective in combating them; the pandemic's impact on the U.S. and global economies and consumer behavior and health care utilization patterns; and the timing, scope and impact of any additional stimulus legislation as well as other federal, state and local governmental responses to the pandemic. Those primary drivers are beyond our knowledge and control. As a result, the impact COVID-19 will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be adverse and material. COVID-19 also may result in legal and regulatory proceedings, investigations and claims against us.

Risks Relating to Our Businesses

We may not be able to accurately forecast health care and other benefit costs, which could adversely affect our Health Care Benefits segment's operating results. There can be no assurance that future health care and other benefits costs will not exceed our projections.

As a result of COVID-19, the current economic environment is adverse and less predictable than recently experienced, which has caused and may continue to cause unanticipated and significant volatility in our health care and other benefits costs, including COVID-19 related testing and vaccination and post-acute care skilled nursing facility and behavioral health costs. In January 2021, the President of the United States issued an executive order to support government efforts to expand access, availability and use of COVID-19 diagnostic, screening and surveillance and addressed the cost of COVID-19 testing by facilitating COVID-19 testing free of charge to those who lack comprehensive health insurance and clarifying group health plans' and health insurance issuers' obligations to provide coverage for COVID-19 testing. In January 2022, the HHS announced that commercial health insurers must cover the cost of up to eight rapid COVID-19 OTC test kits per individual per 30-day period. In addition, the timing of vaccine administration to the general public and related costs as well as the identification of new, more infectious strains of the COVID-19 virus and whether the vaccines will be effective against such new strains are uncertain and may impact our MBR. Premiums for our Insured Health Care Benefits products, which comprised 93%

of our Health Care Benefits revenues for 2021, are priced in advance based on our forecasts of health care and other benefit costs during a fixed premium period, which is generally twelve months. These forecasts are typically developed several months before the fixed premium period begins, are influenced by historical data (and recent historical data in particular), are dependent on our ability to anticipate and detect medical cost trends and changes in our members' behavior and health care utilization patterns and medical claim submission patterns and require a significant degree of judgment. For example, our revenue on Medicare policies is based on bids submitted in June of the year before the contract year. Cost increases in excess of

our projections cannot be recovered in the fixed premium period through higher premiums. As a result, our profits are particularly sensitive to the accuracy of our forecasts of the increases in health care and other benefit costs that we expect to occur and our ability to anticipate and detect medical cost trends. For 2022, those forecasts include adjustments made to pricing based on prospective expectations for liabilities due to testing, vaccines, direct COVID-19 treatment and deferred care. Risk-adjusted revenue has been adjusted for deferred care, and forecasted enrollment considers assumptions about the economic environment, though COVID-19 related impacts remain uncertain. During periods when health care and other benefit costs, utilization and/or medical costs trends experience significant volatility and medical claim submission patterns are changing rapidly as a result of COVID-19, accurately detecting, forecasting, managing, reserving and pricing for our (and our self-insured customers') medical cost trends and incurred and future health care and other benefits costs is more challenging. There can be no assurance regarding the accuracy of the health care or other benefit cost projections reflected in our pricing, and our health care and other benefit costs (including COVID-19 related testing and vaccination and post-acute care skilled nursing facility and behavioral health costs) are affected by COVID-19 and other external events over which we have no control. Even relatively small differences between predicted and actual health care and other benefit costs as a percentage of premium revenues can result in significant adverse changes in our Health Care Benefits segment's operating results.

A number of factors contribute to rising health care and other benefit costs, including COVID-19, previously uninsured members entering the health care system, changes in members' behavior and health care utilization patterns, turnover in our membership, additional government mandated benefits or other regulatory changes (including under the Families First Act, the CARES Act, and the American Rescue Plan Act), changes in the health status of our members, the aging of the population and other changing demographic characteristics, advances in medical technology, increases in the number and cost of prescription drugs (including specialty pharmacy drugs and ultra-high cost drugs and therapies), direct-to-consumer marketing by drug manufacturers, the increasing influence of social media on our members' health care utilization and other behaviors, changes in health care practices and general economic conditions (such as inflation and employment levels). In addition, government-imposed limitations on Medicare and Medicaid reimbursements to health plans and providers have caused the private sector to bear a greater share of increasing health care and other benefits costs over time, and future amendments to the ACA that increase the uninsured population may amplify this problem. Other factors that affect our health care and other benefit costs include epidemics or other pandemics, changes as a result of the ACA, changes to the ACA and other changes in the regulatory environment, the evolution toward a consumer driven business model, new technologies, influenza-related health care costs (which may be substantial and higher than we expected), clusters of high-cost cases, health care provider and member fraud, and numerous other factors that are or may be beyond our control. For example, the 2020-2021 influenza season was impacted by efforts taken to reduce the spread of COVID-19; and the 2019-2020 influenza season had an earlier than average start and had a higher incidence of influenza than the 2018-2019 influenza season.

Our Health Care Benefits segment's operating results and competitiveness depend in large part on our ability to appropriately manage future health care and other benefit costs through underwriting criteria, product design, provider network configuration, negotiation of favorable provider contracts and medical management programs. Our medical cost management programs may not be successful and may have a smaller impact on health care and benefit costs than we expect. The factors described above may adversely affect our ability to predict and manage health care and other benefit costs, which can adversely affect our competitiveness and operating results.

Furthermore, if we are not able to accurately and promptly anticipate and detect medical cost trends or accurately estimate the cost of incurred but not yet reported claims or reported claims that have not been paid, our ability to take timely corrective actions to limit future health care costs and reflect our current benefit cost experience in our pricing process may be limited, which would further amplify the extent of any adverse impact on our operating results. These risks are particularly acute during periods when health care and other benefit costs, utilization and/or medical cost trends experience significant volatility and medical claim submission patterns are changing rapidly as a result of COVID-19. Such risks are further magnified by the ACA and other existing and future legislation and regulations that limit our ability to price for our projected and/or experienced increases in utilization and/or medical cost trends.

There can be no assurance that future health care and other benefits costs will not exceed our projections.

Adverse economic conditions in the U.S. and abroad can materially and adversely impact our businesses, operating results, cash flows and financial condition, and we do not expect these conditions to improve in the near future.

Adverse economic conditions in the U.S. and abroad, including those caused by COVID-19, can materially and adversely impact our businesses, operating results, cash flows and financial condition, including:

- In our Pharmacy Services segment, by causing drug utilization to decline, reducing demand for PBM services and adversely affecting the financial health of our PBM clients.
- In our Retail/LTC segment, by causing drug utilization to decline, changing consumer purchasing power, preferences and/or spending patterns leading to reduced consumer demand for products sold in our stores and adversely affecting the financial health of our LTC pharmacy customers.
- By causing our existing customers to reduce workforces (including due to business failures), which would reduce our revenues, the number of covered lives in our PBM clients and/or the number of members our Health Care Benefits segment serves.
- By causing our clients and customers and potential clients and customers, particularly those with the most employees or members, and state and local governments, to force us to compete more vigorously on factors such as price and service, including service, discount and other performance guarantees, to retain or obtain their business.
- By causing customers and potential customers of our Health Care Benefits and Retail/LTC segments to purchase fewer products and/or products that generate less profit for us than the ones they currently purchase or otherwise would have purchased.
- By causing customers and potential customers of our Health Care Benefits segment, particularly smaller employers and individuals, to forego obtaining or renewing their health and other coverage with us.
- In our Health Care Benefits segment, by causing unanticipated increases and volatility in utilization of medical and other covered services, including COVID-19 related testing, vaccination and behavioral health services, by our medical members, changes in medical claim submission patterns and/or increases in medical unit costs and/or provider behavior, each of which would increase our costs and limit our ability to accurately detect, forecast, manage, reserve and price for our (and our self-insured customers') medical cost trends and incurred and future health care and other benefits costs.
- By increasing medical unit costs and causing changes in provider behavior in our Health Care Benefits segment as hospitals and other providers attempt to maintain revenue levels in their efforts to adjust to their own COVID-19-related and other economic challenges.
- By weakening the ability or perceived ability of the issuers and/or guarantors of the debt or other securities we hold in our investment portfolio to perform on their obligations to us, which could result in defaults in those securities and has reduced, and may further reduce, the value of those securities and has created, and may continue to create, net realized capital losses for us that reduce our operating results.
- By weakening the ability of our customers, including self-insured customers in our Health Care Benefits segment, medical providers and the other companies with which we do business as well as our medical members to perform their obligations to us or causing them not to perform those obligations, either of which could reduce our operating results.
- By weakening the ability of our former subsidiaries and/or their purchasers to satisfy their lease obligations that we have guaranteed and causing the Company to be required to satisfy those obligations.
- By weakening the financial condition of other insurers, including long-term care insurers and life insurers, which increases the risk that we will receive significant assessments for obligations of insolvent insurers to policyholders and claimants.
- By causing, over time, inflation that could cause interest rates to increase and thereby increase our interest expense and reduce our operating results, as well as decrease the value of the debt securities we hold in our investment portfolio, which would reduce our operating results and/or adversely affect our financial condition.

Furthermore, reductions in workforce by our customers can cause unanticipated increases in the health care and other benefits costs of our Health Care Benefits segment. For example, our business associated with members who have elected to receive benefits under Consolidated Omnibus Budget Reconciliation Act (known as "COBRA") typically has an MBR that is significantly higher than our overall Commercial MBR.

Each of our segments operates in a highly competitive and evolving business environment; and operating income in the industries in which we compete may decline.

Each of our segments, Health Care Benefits, Pharmacy Services, which includes our PBM business, and Retail/LTC, operates in a highly competitive and evolving business environment. Specifically:

- As competition increases in the geographies in which we operate, including competition from new entrants, a significant increase in price compression and/or reimbursement pressures could occur, and this could require us to reevaluate our pricing structures to remain competitive.
- In our Health Care Benefits segment we are seeking to substantially grow our Medicaid, dual eligible and dual eligible special needs plan membership over the next several years. In many instances, to acquire and retain our government

customers' business, we must bid against our competitors in a highly competitive environment. Winning bids often are challenged successfully by unsuccessful bidders, and may also be withdrawn or cancelled by the issuing agency.

- Customer contracts in our Health Care Benefits segment are generally for a period of one year, and our customers have considerable flexibility in moving between us and our competitors. One of the key factors on which we compete for customers, especially in uncertain economic environments, is overall cost. We are therefore under pressure to contain premium price increases despite being faced with increasing health care and other benefit costs and increasing operating costs. If we are unable to increase our prices to reflect, or otherwise mitigate the impact of, increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose members to competitors with more favorable pricing, adversely affecting our revenues and operating results. In response to rising prices, our customers may elect to self-insure or to reduce benefits in order to limit increases in their benefit costs. Alternatively, our customers may purchase different types of products from us that are less profitable. Such elections may result in reduced membership in our more profitable Insured products and/or lower premiums for our Insured products, which may adversely affect our revenues and operating results, although such elections also may reduce our health care and other benefit costs. In addition, our Medicare, Medicaid and CHIP products are subject to termination without cause, periodic re-bid, rate adjustment and program redesign, as customers seek to contain their benefit costs, particularly in an uncertain economy, and our exposure to this risk is increasing as we grow our Government products membership. These actions may adversely affect our membership, revenues and operating results.
- We requested increases in our premium rates in our Commercial Health Care Benefits business for 2021 and expect to request increases in those rates for 2022 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and rating limits, and significant assessments, fees and taxes imposed by federal and state governments, including as a result of the ACA. Our rates also must be adequate to reflect the risk that our products will be selected by people with a higher risk profile or utilization rate than the pool of participants we anticipated when we established pricing for the applicable products (also known as "adverse selection"), particularly in small group Commercial products. These rate increases may be significant and thus heighten the risks of adverse publicity, adverse regulatory action and adverse selection and the likelihood that our requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.
- The competitive success of our Pharmacy Services segment is dependent on our ability to establish and maintain contractual relationships with network pharmacies as PBM clients evaluate adopting narrow or restricted retail pharmacy networks.
- The competitive success of our Retail/LTC segment and our specialty pharmacy operations is dependent on our ability to establish and maintain contractual relationships with PBMs and other payors on acceptable terms as the payors' clients evaluate adopting narrow or restricted retail pharmacy networks.
- In our PBM business, we maintain contractual relationships with brand name drug manufacturers that provide for purchase discounts and/or rebates on drugs dispensed by pharmacies in our retail network and by our specialty and mail order pharmacies (all or a portion of which may be passed on to clients). Manufacturer's rebates often depend on a PBM's ability to meet contractual requirements, including the placement of a manufacturer's products on the PBM's formularies. If we lose our relationship with one or more drug manufacturers, or if the discounts or rebates provided by drug manufacturers decline, our operating results, cash flows and/or prospects could be adversely affected.
- The PBM industry has been experiencing price compression as a result of competitive pressures and increased client demands for lower prices, increased revenue sharing, including sharing in a larger portion of rebates received from drug manufacturers, enhanced service offerings and/or higher service levels. Marketplace dynamics and regulatory changes also have adversely affected our ability to offer plan sponsors pricing that includes the use of retail "differential" or "spread," which could adversely affect our future profitability, and we expect these trends to continue.
- Our retail pharmacy, specialty pharmacy and LTC pharmacy operations have been affected by reimbursement pressure caused by competition, including client demands for lower prices, generic drug pricing, earlier than expected generic drug introductions and network reimbursement pressure. If we are unable to increase our prices to reflect, or otherwise mitigate the impact of, increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose customers to competitors with more favorable pricing, adversely affecting our revenues and operating results.

- A shift in the mix of our pharmacy prescription volume towards programs offering lower reimbursement rates as a result of competition or otherwise could adversely affect our margins, including the ongoing shift in pharmacy mix towards 90-day prescriptions at retail and the ongoing shift in pharmacy mix towards Medicare Part D prescriptions.
- PBM client contracts often are for a period of approximately three years. However, PBM clients may require early or periodic re-negotiation of pricing prior to contract expiration. PBM clients are generally well informed, can move between us and our competitors and often seek competing bids prior to expiration of their contracts. We are therefore under pressure to contain price increases despite being faced with increasing drug costs and increasing operating costs. If we are unable to increase our prices to reflect, or otherwise mitigate the impact of, increasing costs, our profitability will be adversely

affected. If we are unable to limit our price increases, we may lose customers to competitors with more favorable pricing, adversely affecting our revenues and operating results.

- The operating results and margins of our LTC business are further affected by the increased efforts of health care payors to negotiate reduced or capitated pricing arrangements and by the financial health of, and purchases and sales of, our LTC customers.

In addition, competitors in each of our businesses may offer services and pricing terms that we may not be willing or able to offer. Competition also may come from new entrants and other sources in the future. Unless we can demonstrate enhanced value to our clients through innovative product and service offerings in the rapidly changing health care industry, we may be unable to remain competitive.

Disruptive innovation by existing or new competitors could alter the competitive landscape in the future and require us to accurately identify and assess such alterations and make timely and effective changes to our strategies and business model to compete effectively. For example, decisions to buy our Health Care Benefits and Pharmacy Services products and services increasingly are made or influenced by consumers, either through direct purchasing (e.g., Medicare Advantage plans and PDPs) or through Public Exchanges and private health insurance exchanges that allow individual choice. Consumers also are increasingly seeking to access consumer goods and health care products and services locally and through other direct channels such as mobile devices and websites. To compete effectively in the consumer-driven marketplace, we will be required to develop or acquire new capabilities, attract new talent and develop new service and distribution relationships that respond to consumer needs and preferences.

Changes in marketplace dynamics or the actions of competitors or manufacturers, including industry consolidation, the emergence of new competitors and strategic alliances, and decisions to exclude us from new narrow or restricted retail pharmacy networks could materially and adversely affect our businesses, operating results, cash flows and/or prospects.

We can provide no assurance that we will be able to compete successfully on Public Exchanges or that our pricing or other actions will result in the profitability of our Public Exchange products.

In January 2022, we entered into the Public Exchanges in eight states. To compete effectively on Public Exchanges, we have developed or acquired the technology, systems, tools and talent necessary to interact with Public Exchanges and engage Public Exchange consumers through enhanced consumer-focused sales, marketing channels and customer interfaces. We have also created new customer service programs and product offerings. While participating on the Public Exchanges, we will have to respond to pricing and other actions taken by existing competitors and regulators as well as potentially disruptive new entrants, which could reduce our profit margins. Due to the price transparency provided by Public Exchanges, when we market products we face competitive pressures from existing and new competitors who may have lower cost structures. Our competitors may bring their Public Exchange and other consumer products to market more quickly, have greater experience marketing to consumers and/or may be targeting the higher margin portions of our business. We can provide no assurance that we will be able to compete successfully or profitably on Public Exchanges or that we will be able to benefit from any opportunities presented by Public Exchanges.

In addition, there can be no assurance that our pricing or other actions will result in the profitability of our Public Exchange products in 2022 or any future year. We have set 2022 premium rates for our Public Exchange products based on our projections, including as to the health status and quantity of membership and utilization of medical and/or other covered services by members. The accuracy of the projections reflected in our pricing may be impacted by (i) adverse selection among individuals who require or utilize more expensive medical and/or other covered services, (ii) other plans' withdrawals from participation in the Public Exchanges we serve and (iii) legislation, regulations, enforcement activity and/or judicial decisions that cause Public Exchanges to operate in a manner different than what we projected in setting our premium rates.

A change in our Health Care Benefits product mix may adversely affect our profit margins.

Our Insured Health Care Benefits products that involve greater potential risk generally tend to be more profitable than our ASC products. Historically, smaller employer groups have been more likely to purchase Insured Health Care Benefits products because such purchasers are generally unable or unwilling to bear greater liability for health care expenditures, although over the last several years even relatively small employers have moved to ASC products. We

also serve, and expect to grow our business with, government-sponsored programs, including Medicare and Medicaid, that are subject to competitive bids and have lower profit margins than our Commercial Insured Health Care Benefits products. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on the Health Care Benefits segment's operating results.

Negative public perception of the industries in which we operate, or of our industries' or our practices, can adversely affect our businesses, operating results, cash flows and prospects.

Our brand and reputation are two of our most important assets, and the industries in which we operate have been and are negatively perceived by the public from time to time. Negative publicity may come as a result of adverse media coverage, litigation against us and other industry participants, the ongoing public debates over drug pricing, PBMs, government involvement in drug pricing and purchasing, changes to the ACA, "surprise" medical bills, governmental hearings and/or investigations, actual or perceived shortfalls regarding our industries' or our own products and/or business practices (including PBM operations, drug pricing and insurance coverage determinations) and social media and other media relations activities. Negative publicity also may come from a failure to meet customer expectations for consistent, high quality and accessible care. This risk may increase as we continue to offer products and services that make greater use of data and as our business model becomes more focused on delivering health care to consumers.

In addition, by working with the U.S. government in the distribution and administration of the COVID-19 vaccine, the Company may be subject to negative publicity related to the government's actions in response to COVID-19 that are outside of the ability of the Company to control.

Negative public perception and/or publicity of our industries in general, or of us or our key vendors, brokers or product distribution networks in particular, can further increase our costs of doing business and adversely affect our operating results and our stock price by:

- adversely affecting our brand and reputation;
- adversely affecting our ability to market and sell our products and/or services and/or retain our existing customers and members;
- requiring us to change our products and/or services;
- reducing or restricting the revenue we can receive for our products and/or services; and/or
- increasing or significantly changing the regulatory and legislative requirements with which we must comply.

We must maintain and improve our relationships with our retail and specialty pharmacy customers and increase the demand for our products and services, including proprietary brands.

The success of our businesses depends in part on customer loyalty, superior customer service and our ability to persuade customers to frequent our retail stores and online sites and to purchase products in additional categories and our proprietary brands. Failure to timely identify or effectively respond to changing consumer preferences and spending patterns, and evolving demographic mixes in the communities we serve, an inability to expand the products being purchased by our clients and customers, or the failure or inability to obtain or offer particular categories of products could adversely affect our relationship with our customers and clients and the demand for our products and services and could result in excess inventories of products.

We offer our retail customers proprietary brand products that are available exclusively at our retail stores and through our online retail sites. The sale of proprietary products subjects us to unique risks including potential product liability risks, mandatory or voluntary product recalls, potential supply chain and distribution chain disruptions for raw materials and finished products, our ability to successfully protect our intellectual property rights and the rights of applicable third parties, and other risks generally encountered by entities that source, market and sell private-label products. We also face similar risks for the other products we sell in our retail operations, including supply chain and distribution chain disruption risk. Any failure to adequately address some or all of these risks could have an adverse effect on our retail business, operating results, cash flows and/or financial condition. Additionally, an increase in the sales of our proprietary brands may adversely affect our sales of products owned by our suppliers and adversely impact certain of our supplier relationships. Our ability to locate qualified, economically stable suppliers who satisfy our requirements, and to acquire sufficient products in a timely and effective manner, is critical to ensuring, among other things, that customer confidence is not diminished. Any failure to develop sourcing relationships with a broad and deep supplier base could adversely affect our operating results and erode customer loyalty.

We also could be adversely affected if we fail to identify or effectively respond to changes in marketplace dynamics. For example, specialty pharmacy represents a significant and growing proportion of prescription drug spending in the U.S., a significant portion of which is dispensed outside of traditional retail pharmacies. Because our specialty pharmacy business focuses on complex and high-cost medications, many of which are made available by manufacturers to a limited number of pharmacies (so-called limited distribution drugs) that serve a relatively limited universe of patients, the future growth of our

specialty pharmacy business depends largely upon expanding our access to key drugs and penetration in certain treatment categories. Any contraction of our base of patients or reduction in demand for the prescriptions we currently dispense could have an adverse effect on our specialty pharmacy business, operating results and cash flows.

We face risks relating to the availability, pricing and safety profiles of prescription drugs that we purchase and sell.

The profitability of our Retail/LTC and Pharmacy Services segments is dependent upon the utilization of prescription drug products. We dispense significant volumes of brand name and generic drugs from our retail, LTC, specialty and mail order pharmacies, and the retail pharmacies in our PBM's network also dispense significant volumes of brand name and generic drugs. Our revenues, operating results and cash flows may decline if physicians cease writing prescriptions for drugs or the utilization of drugs is reduced, including due to:

- increased safety risk profiles or regulatory restrictions;
- manufacturing or other supply issues;
- a reduction in drug manufacturers' participation in federal programs;
- certain products being withdrawn by their manufacturers or transitioned to over-the-counter products;
- future FDA rulings restricting the supply or increasing the cost of products;
- the introduction of new and successful prescription drugs or lower-priced generic alternatives to existing brand name products; or
- inflation in the price of drugs.

In addition, increased utilization of generic drugs (which normally yield a higher gross profit rate than equivalent brand name drugs) has resulted in pressure to decrease reimbursement payments to retail, mail order, specialty and LTC pharmacies for generic drugs, causing a reduction in our margins on sales of generic drugs. Consolidation within the generic drug manufacturing industry and other external factors may enhance the ability of manufacturers to sustain or increase pricing of generic drugs and diminish our ability to negotiate reduced generic drug acquisition costs. Any inability to offset increased brand name or generic prescription drug acquisition costs or to modify our activities to lessen the financial impact of such increased costs could have a significant adverse effect on our operating results.

The reserves we hold for expected claims in our Insured Health Care Benefits products are based on estimates that involve an extensive degree of judgment and are inherently variable. Any reserve, including a premium deficiency reserve, may be insufficient. If actual claims exceed our estimates, our operating results could be materially adversely affected, and our ability to take timely corrective actions to limit future costs may be limited.

A large portion of health care claims are not submitted to us until after the end of the quarter in which services are rendered by providers to our members. Our reported health care costs payable for any particular period reflect our estimates of the ultimate cost of such claims as well as claims that have been reported to us but not yet paid. We also must estimate the amount of rebates payable under the MLR rules of the ACA, CMS and the OPM and the amounts payable by us to, and receivable by us from, the United States federal government under the ACA's remaining premium stabilization program.

Our estimates of health care costs payable are based on a number of factors, including those derived from historical claim experience, but this estimation process also makes use of extensive judgment. Considerable variability is inherent in such estimates, and the accuracy of the estimates is highly sensitive to changes in medical claims submission and processing patterns and/or procedures, turnover and other changes in membership, changes in product mix, changes in the utilization of medical and/or other covered services, including prescription drugs, changes in medical cost trends, changes in our medical management practices and the introduction of new benefits and products. We estimate health care costs payable periodically, and any resulting adjustments, including premium deficiency reserves, are reflected in current-period operating results within benefit costs. For example, as of December 31, 2021 and 2020, we established a premium deficiency reserve of $16 million and $11 million, respectively, related to Medicaid products in the Health Care Benefits segment. A worsening (or improvement) of health care cost trend rates or changes in claim payment patterns from those that we assumed in estimating health care costs payable as of December 31, 2021 would cause these estimates to change in the near term, and such a change could be material.

Furthermore, if we are not able to accurately and promptly anticipate and detect medical cost trends or accurately estimate the cost of incurred but not yet reported claims or reported claims that have not been paid, our ability to take timely corrective actions to limit future health care costs and reflect our current benefit cost experience in our pricing process may be limited, which would further exacerbate the extent of any adverse impact on our operating results. These risks are particularly acute during and following periods when utilization of medical and/or other covered services and/or medical cost trends are below

recent historical levels and in products where there is significant turnover in our membership each year, and such risks are further magnified by the ACA and other legislation and regulations that limit our ability to price for our projected and/or experienced increases in utilization and/or medical cost trends.

Our operating results are affected by the health of the economy in general and in the geographies we serve.

Our businesses are affected by the U.S. economy and consumer confidence in general and in the geographies we serve, including various economic factors, including inflation and changes in consumer purchasing power, preferences and/or spending patterns. An unfavorable, uncertain or volatile economic environment could cause a decline in drug utilization, an increase in health care utilization and dampen demand for PBM services as well as consumer demand for products sold in our retail stores.

If our customers' operating and financial performance deteriorates, or they are unable to make scheduled payments or obtain adequate financing, our customers may not be able to pay timely, or may delay payment of, amounts owed to us. Any inability of our customers to pay us for our products and services may adversely affect our businesses, operating results and cash flows. In addition, both state and federal government sponsored payers, as a result of budget deficits or spending reductions, may suspend payments or seek to reduce their health care expenditures resulting in our customers delaying payments to us or renegotiating their contracts with us.

Further, economic conditions including interest rate fluctuations, changes in capital market conditions and regulatory changes may affect our ability to obtain necessary financing on acceptable terms, our ability to secure suitable store locations under acceptable terms, our ability to execute sale-leaseback transactions under acceptable terms and the value of our investment portfolio. Adverse changes in the U.S. economy, consumer confidence and economic conditions could have an adverse effect on our businesses and financial results. This adverse effect could be further exacerbated by the increasing prevalence of high deductible health plans and health plan designs favoring co-insurance over co-payments as members and other consumers may decide to postpone, or not to seek, medical treatment which may lead them to incur more expensive medical treatment in the future and/or decrease our prescription volumes.

In addition, our Health Care Benefits membership remains concentrated in certain U.S. geographies and in certain industries. Unfavorable changes in health care or other benefit costs or reimbursement rates or increased competition in those geographic areas where our membership is concentrated could therefore have a disproportionately adverse effect on our Health Care Benefits segment's operating results. Our Health Care Benefits membership has been and may continue to be affected by workforce reductions by our customers due to adverse and/or uncertain general economic conditions, especially in the U.S. geographies and industries where our membership is concentrated. As a result, we may not be able to profitably grow and diversify our Health Care Benefits membership geographically, by product type or by customer industry, and our revenues and operating results may be disproportionately affected by adverse changes affecting our customers.

We are exposed to risks relating to the solvency of other insurers.

We are subject to assessments under guaranty fund laws existing in all states for obligations of insolvent insurance companies (including long-term care insurers), HMOs, ACA co-ops and other payors to policyholders and claimants. For example, in the first quarter of 2017, Aetna recorded a discounted estimated liability expense of $231 million pretax for our estimated share of future assessments for long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries. Guaranty funds are maintained by state insurance commissioners to protect policyholders and claimants in the event that an insurer, HMO, ACA co-op and/or other payor becomes insolvent or is unable to meet its financial obligations. These funds are usually financed by assessments against insurers regulated by a state. Future assessments may have an adverse effect on our operating results and cash flows.

Extreme events, or the threat of extreme events, could materially impact our businesses and health care (including behavioral health) costs.

Nuclear, biological or other attacks, or other acts of violence, including active shooter situations, whether as a result of war or terrorism or otherwise; other man-made disasters; natural disasters, such as hurricanes, tropical storms, floods, fires, earthquakes, tsunamis, cyclones, typhoons or extreme weather conditions such as major or extended winter storms, droughts and tornados, whether as a result of climate change or otherwise; epidemics; pandemics and

other extreme events can affect the U.S. economy in general, our industries and us specifically. In particular, such extreme events or the threat of such extreme events could result in significant health care (including behavioral health) costs, which also would be affected by the government's actions and the responsiveness of public health agencies and other insurers. Such extreme events or the threat of

such extreme events also could disrupt our supply chains and/or our distribution chains for the products we sell. In addition, our employees and those of our vendors are concentrated in certain large, metropolitan areas which may be particularly exposed to these events. Such events could adversely affect our businesses, operating results and cash flows, and, in the event of extreme circumstances, our financial condition or viability, particularly if our responses to such events are less adequate than those of our competitors.

We may be unable to achieve our environmental, social and governance goals.
We are dedicated to corporate social responsibility and sustainability and face pressures from our colleagues, customers, and stockholders to make significant advancements in environmental, social and governance matters. In part to address these concerns, we established certain goals as part of our ESG strategy. Achievement of our goals is subject to risks and uncertainties, many of which are outside of our control, and it is possible that we may fail to achieve these goals or that our colleagues, customers, or stockholders might not be satisfied with our efforts. These risks and uncertainties include, but are not limited to: our ability to execute our operational strategies and achieve our goals within the currently projected costs and the expected timeframes; the availability and cost of renewable energy and other materials; compliance with, and changes or additions to, global and regional regulations, taxes, charges, mandates or requirements relating to climate-related goals; labor-related regulations and requirements that restrict or prohibit our ability to impose requirements on third party contractors; the actions of competitors and competitive pressures; an acquisition of or merger with another company that has not adopted similar goals or whose progress towards reaching its goals is not as advanced as ours; and the pace of regional and global recovery from the COVID-19 pandemic. A failure to meet our goals could adversely affect public perception of our business, employee morale or customer or stockholder support.

Further, an increasing percentage of colleagues, customers, and stockholders considers sustainability factors in making employment, consumer health care and investment decisions. If we are unable to meet our goals, we may lose colleagues, and have difficulty recruiting new colleagues, investors, customers, or partners, our stock price may be negatively impacted, our reputation may be negatively affected, and it may be more difficult for us to compete effectively, all of which would have an adverse effect on our business, operating results, and financial condition.

Risks From Changes in Public Policy and Other Legal and Regulatory Risks

We are subject to potential changes in public policy, laws and regulations, including reform of the U.S. health care system, which can adversely affect our businesses. Entitlement program reform, if it occurs, could have a material adverse effect on our businesses, operations and/or operating results.

The political environment in which we operate remains uncertain. It is reasonably possible that our business operations and operating results could be materially adversely affected by legislative, regulatory and public policy changes at the federal or state level, increased government involvement in drug reimbursement, pricing, purchasing and/or importation and/or increased regulation of PBMs, including: changes to the regulatory environment for health care and related benefits, including Medicare, the ACA, and related Public Exchange regulations; changes to laws or regulations governing drug reimbursement and/or pricing; changes to the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs; changes to laws and/or regulations governing drug manufacturers' rebates; changes to laws and/or regulations governing reimbursements paid to pharmacists by and/or reporting required by PBMs; changes to immigration policies and/or other public policy initiatives. It is not possible to predict whether or when any such changes will occur or what form any such changes may take (including through the use of U.S. Presidential Executive Orders). Other significant changes to health care and related benefits system legislation or regulation as well as changes with respect to tax and trade policies, tariffs and other government regulations affecting trade between the United States and other countries also are possible and could adversely affect our businesses. If we fail to respond adequately to such changes, including by implementing strategic and operational initiatives, or do not respond as effectively as our competitors, our businesses, operations and operating results may be materially adversely affected.

Efforts to amend the ACA and related regulations are possible. It is also possible that federal and state governments will continue to enact and seriously consider many broad-based legislative and regulatory proposals that will or could materially impact various aspects of the health care and related benefits system and our businesses. Further changes to federal health care and related benefits laws, including the ACA, drug reimbursement and pricing laws, laws governing PBMs and/or laws governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, are probable. We cannot predict the effect, if any, that new health care and

related benefits legislation, future changes to the ACA or the implementation of or failure to implement the outstanding provisions of ACA, may have on our Health Care Benefits, Pharmacy Services and/or retail pharmacy, LTC pharmacy operations and/or operating results. The federal and many

state governments also are considering changes in the interpretation, enforcement and/or application of existing programs, laws and regulations, including changes to payments under and funding of Medicare and Medicaid programs and increased regulation of PBMs.

Further, changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to additional regulation of PBMs (including network restrictions, formulary management affiliate reimbursement, contractual guarantees and reconciliations, or other PBM services), drug pricing or purchasing, patent term extensions and/or purchase discount and/or rebate arrangements with drug manufacturers also could reduce the discounts or rebates we receive. Changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to claims processing and billing, including our ability to use MAC lists and collect transmission fees, also could adversely affect our profitability. For example, on October 29, 2020, the HHS released a final rule requiring health insurers to disclose drug pricing and cost-sharing information. The final rule requires group health plans and health insurance issuers in the individual and group markets to disclose cost-sharing information upon request, to a participant, beneficiary, or enrollee, which, unless otherwise indicated, for the purpose of the final rules includes an authorized representative, and requires plans and issuers to disclose in-network provider rates, historical out-of-network allowed amounts and the associated billed charges, and negotiated rates for prescription drugs. While the specific regulation requiring PBMs to disclose negotiated price concessions was paused under federal guidance released in August 2021, if it resurfaces, the regulation may result in drug manufacturers lowering discounts or rebates, resulting in higher drug costs for patients and impacting the ability of the Company to negotiate drug prices and provide competitive products and services to consumers.

In addition, in November 2020, the HHS released the Rebate Rule, which eliminates the regulatory safe harbor from prosecution under the AKS for rebates from pharmaceutical companies to PBMs in Medicare Part D and in Medicaid MCOs, replacing it with two far narrower safe harbors designed to directly benefit patients with high out-of-pocket costs and to change the way PBMs are compensated. The new safe harbors are (i) for rebates which are passed on to the patient at the point of sale and (ii) for flat service fee payments made to PBMs which cannot be tied to the list prices of drugs. The PCMA, which represents PBMs, has filed a suit in an effort to block the Rebate Rule, claiming that the Rebate Rule would lead to higher premiums in Medicare Part D and was adopted in an unlawful manner. It is unclear whether the Rebate Rule will be enforceable, whether pharmaceutical companies will respond by reducing list prices, whether list prices in the private market may also be reduced, and what the resulting impact will be to PBMs or the Company. The Bipartisan Infrastructure Act of 2021 delays the effective date of the rebate rule to January 2026, and pending Reconciliation legislation would fully repeal the Rebate Rule.

Additionally, the Consolidated Appropriations Act of 2021 was signed into law in December 2020 and contains transparency provisions requiring group health plans and health insurance issuers to report certain prescription drug costs, overall spending on health services and prescription drugs, and information about premiums and the impact of rebates and other remuneration on premiums and out-of-pocket costs to the Tri-Departments. No later than 18 months after the first submission and bi-annually thereafter, the Tri-Departments will release a public report on drug pricing trends, drug reimbursement, and the impact of drug prices on premiums. In August, the Tri-Departments deferred enforcement of both the December 2021 deadline for reporting 2020 plan year data and the June 2022 deadline for reporting 2021 plan year data to December 2022.

We cannot predict the enactment or content of new legislation or regulations or changes to existing laws or regulations or their enforcement, interpretation or application, or the effect they will have on our business operations or operating results, which could be materially adverse. Even if we could predict such matters, it is not possible to eliminate the adverse impact of public policy changes that would fundamentally change the dynamics of one or more of the industries in which we compete. Examples of such changes include: the federal or one or more state governments fundamentally restructuring or reducing the funding available for Medicare, Medicaid, dual eligible or dual eligible special needs plan programs, increasing its involvement in drug reimbursement, pricing, purchasing and/or importation, changing the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, changing the tax treatment of health or related benefits, or significantly altering the ACA. The likelihood of adverse changes remains high due to state and federal budgetary pressures, and our businesses and operating results could be materially and adversely affected by such changes, even if we correctly predict their occurrence.

For more information on these matters, see "Government Regulation" included in Item 1 of this 10-K.

If we fail to comply with applicable laws and regulations, many of which are highly complex, we could be subject to significant adverse regulatory actions, including monetary penalties, or suffer brand and reputational harm.

Our businesses are subject to extensive regulation and oversight by state, federal and international governmental authorities. The laws and regulations governing our operations and interpretations of those laws and regulations, including those related to human capital and climate change, are increasing in number and complexity, change frequently and can be inconsistent or conflict with one another. In general, these laws and regulations are designed to benefit and protect customers, members and providers rather than us or our investors. In addition, the governmental authorities that regulate our businesses have broad latitude to make, interpret and enforce the laws and regulations that govern us and continue to interpret and enforce those laws and regulations more strictly and more aggressively each year. We also must follow various restrictions on certain of our businesses and the payment of dividends by certain of our subsidiaries put in place by certain state regulators.

Certain of our Pharmacy Services and Retail/LTC operations, products and services are subject to:

- the clinical quality, patient safety and other risks inherent in the dispensing, packaging and distribution of drugs and other health care products and services, including claims related to purported dispensing and other operational errors (any failure by our Pharmacy Services and/or Retail/LTC operations to adhere to the laws and regulations applicable to the dispensing of drugs could subject us to civil and criminal penalties);
- federal and state anti-kickback and other laws that govern our relationship with drug manufacturers, customers and consumers;
- compliance requirements under ERISA, including fiduciary obligations in connection with the development and implementation of items such as drug formularies and preferred drug listings; and
- federal and state legislative proposals and/or regulatory activity that could adversely affect pharmacy benefit industry practices.

Our Health Care Benefits products are highly regulated, particularly those that serve Medicare, Medicaid, dual eligible, dual eligible special needs and small group Commercial customers and members. The laws and regulations governing participation in Medicare Advantage (including dual eligible special needs plans), Medicare Part D, Medicaid, and managed Medicaid plans are complex, are subject to interpretation and can expose us to penalties for non-compliance.

The scope of the practices and activities that are prohibited by federal and state false claims acts is the subject of pending litigation. Claims under federal and state false claims acts can be brought by the government or by private individuals on behalf of the government through a *qui tam* or "whistleblower" suit, and we are a defendant in a number of such proceedings. If we are convicted of fraud or other criminal conduct in the performance of a government program or if there is an adverse decision against us under the False Claims Act, we may be temporarily or permanently suspended from participating in government health care programs, including Medicare Advantage, Medicare Part D, Medicaid, dual eligible and dual eligible special needs plan programs, and we also may be required to pay significant fines and/or other monetary penalties. Whistleblower suits have resulted in significant settlements between governmental agencies and health care companies. The significant incentives and protections provided to whistleblowers under applicable law increase the risk of whistleblower suits.

If we fail to comply with laws and regulations that apply to government programs, we could be subject to criminal fines, civil penalties, premium refunds, prohibitions on marketing or active or passive enrollment of members, corrective actions, termination of our contracts or other sanctions which could have a material adverse effect on our ability to participate in Medicare Advantage, Medicare Part D, Medicaid, dual eligible, dual eligible special needs plan and other programs and on our operating results, cash flows and financial condition.

Our businesses, profitability and growth also may be adversely affected by (i) judicial and regulatory decisions that change and/or expand the interpretations of existing statutes and regulations, impose medical or bad faith liability, increase our responsibilities under ERISA or the remedies available under ERISA, or reduce the scope of ERISA pre-emption of state law claims or (ii) other legislation and regulations. For example, in December 2020, the U.S. Supreme Court upheld an Arkansas law that, among other things, mandates a particular pricing methodology, establishes an appeals process for a pharmacy when the reimbursement is below the pharmacy's acquisition cost, permits a pharmacy to reverse and rebill if they cannot procure the drug from its wholesaler at a price equal to or less than the reimbursement rate, prohibits a PBM from reimbursing a pharmacy less than the amount it reimburses an affiliate on a per unit basis, and permits a pharmacy to decline to dispense if the reimbursement is lower than the pharmacy's acquisition cost. Also, in November 2021, the U.S. Court of Appeals for the Eighth Circuit upheld a

North Dakota law that regulates employer-sponsored ERISA health plans and certain PBM practices within Medicare.

If our compliance or other systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions and/or litigation.

In addition to being subject to extensive and complex regulations, many of our contracts with customers include detailed requirements. In order to be eligible to offer certain products or bid on certain contracts, we must demonstrate that we have robust systems and processes in place that are designed to maintain compliance with all applicable legal, regulatory and contractual requirements. These systems and processes frequently are reviewed and audited by our customers and regulators. If our systems and processes designed to maintain compliance with applicable legal and contractual requirements, and to prevent and detect instances of, or the potential for, non-compliance fail or are deemed inadequate, we may suffer brand and reputational harm and be subject to regulatory actions, litigation and other proceedings which may result in damages, fines, suspension or loss of licensure, suspension or exclusion from participation in government programs and/or other penalties, any of which could adversely affect our businesses, operating results, cash flows and/or financial condition.

We routinely are subject to litigation and other adverse legal proceedings, including class actions and qui tam actions. Many of these proceedings seek substantial damages which may not be covered by insurance. These proceedings are costly to defend, may result in changes in our business practices, harm our brand and reputation and adversely affect our businesses and operating results.

PBM, retail pharmacy, mail order pharmacy, specialty pharmacy, LTC pharmacy and health care and related benefits are highly regulated industries whose participants frequently are subject to litigation and other adverse legal proceedings. We are currently subject to various litigation and arbitration matters, investigations, regulatory audits, inspections, government inquiries, and regulatory and other legal proceedings, both inside and outside the U.S. Outside the U.S., contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the U.S. Litigation related to our provision of professional services in our medical clinics, pharmacies and LTC operations is increasing as we expand our services along the continuum of health care.

Litigation, and particularly securities, derivative, collective or class action and *qui tam* litigation, is often expensive and disruptive. Many of the legal proceedings against us seek substantial damages (including non-economic or punitive damages and treble damages), and certain of these proceedings also seek changes in our business practices. While we currently have insurance coverage for some potential liabilities, other potential liabilities may not be covered by insurance, insurers may dispute coverage and/or the amount of our insurance may not be enough to cover the damages awarded or costs incurred. In addition, some types of damages, like punitive damages, may not be covered by insurance, and in some jurisdictions the coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability also may become unavailable or prohibitively expensive in the future.

The outcome of litigation and other adverse legal proceedings is always uncertain, and outcomes that are not justifiable by the evidence or existing law or regulation can and do occur, and the costs incurred frequently are substantial regardless of the outcome. Litigation and other adverse legal proceedings could materially adversely affect our businesses, operating results and/or cash flows because of brand and reputational harm to us caused by such proceedings, the cost of defending such proceedings, the cost of settlement or judgments against us, or the changes in our operations that could result from such proceedings. See Item 3 of this 10-K for additional information.

We frequently are subject to regular and special governmental audits, investigations and reviews that could result in changes to our business practices and also could result in material refunds, fines, penalties, civil liabilities, criminal liabilities and other sanctions.

As one of the largest national retail, mail order, specialty and LTC pharmacy, PBM and health care and related benefits providers, we frequently are subject to regular and special governmental market conduct and other audits, investigations and reviews by, and we receive subpoenas and other requests for information from, various federal and state agencies, regulatory authorities, attorneys general, committees, subcommittees and members of the U.S. Congress and other state, federal and international governmental authorities. For example, we have received CIDs from, and provided documents and information to, the Civil Division of the DOJ in connection with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. CMS and the OIG also are auditing the risk adjustment-related data of certain of our Medicare Advantage plans, and the number of such audits continues to increase. Several such audits, investigations and reviews by governmental authorities currently are pending, some of which may be resolved in 2022, the results of which may be adverse to us.

Federal and state governments have made investigating and prosecuting health care and other insurance fraud, waste and abuse a priority. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical and/or other covered services, improper marketing and violations of patient privacy

rights. The regulations and contractual requirements applicable to us and other industry participants are complex and subject to change, making it necessary for us to invest significant resources in complying with our regulatory and contractual requirements. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources. In addition, our medical costs and the medical expenses of our Health Care Benefits ASC customers may be adversely affected if we do not prevent or detect fraudulent activity by providers and/or members.

Regular and special governmental audits, investigations and reviews by federal, state and international regulators could result in changes to our business practices, and also could result in significant or material premium refunds, fines, penalties, civil liabilities, criminal liabilities or other sanctions, including suspension or exclusion from participation in government programs and suspension or loss of licensure. Any of these audits, investigations or reviews could have a material adverse effect on our businesses, operating results, cash flows and/or financial condition or result in significant liabilities and negative publicity for us.

See "Legal and Regulatory Proceedings" in Note 16 ''Commitments and Contingencies'' included in Item 8 of this 10-K for additional information.

Our litigation and regulatory risk profile are changing as we offer new products and services and expand in business areas beyond our historical core businesses of Health Care Benefits, Pharmacy Services and Retail/LTC.

Historically, we focused primarily on providing Health Care Benefits, Pharmacy Services and Retail/LTC products and services. As a result of our transformation program and other innovation initiatives, we are expanding our presence in the health care space and plan to offer new products and services (such as the home hemodialysis device we are developing) which present a different litigation and regulatory risk profile than the products and services that we historically have offered.

The increased volume of business in areas beyond our historical core businesses and new products and services subject us to litigation and regulatory risks that are different from the risks of providing Health Care Benefits, Pharmacy Services and Retail/LTC products and services and increase significantly our exposure to other risks.

We face unique regulatory and other challenges in our Medicare and Medicaid businesses.

We are seeking to substantially grow the Medicare and Medicaid membership in our Health Care Benefits segment in 2022 and over the next several years. We face unique regulatory and other challenges that may inhibit the growth and profitability of those businesses.

- In January 2021, CMS issued its final notice detailing final 2022 Medicare Advantage benchmark payment rates. Final 2022 Medicare Advantage rates resulted in an increase in industry benchmark rates of approximately 4.1%. We cannot predict future Medicare funding levels, the impact of future federal budget actions or ensure that such changes or actions will not have an adverse effect on our Medicare operating results.
- The organic expansion of our Medicare Advantage and Medicare Part D service area is subject to the ability of CMS to process our requests for service area expansions and our ability to build cost competitive provider networks in the expanded service areas that meet applicable network adequacy requirements. CMS' decisions on our requests for service area expansions also may be affected adversely by compliance issues that arise each year in our Medicare operations.
- CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of the services we provide to our Medicare members. As a result of these audits, we may be subject to significant or material retroactive adjustments to and/or withholding of certain premiums and fees, fines, criminal liability, civil monetary penalties, CMS imposed sanctions (including suspension or exclusion from participation in government programs) or other restrictions on our Medicare, Medicaid and other businesses, including suspension or loss of licensure.
- "Star ratings" from CMS for our Medicare Advantage plans will continue to have a significant effect on our plans' operating results. Only Medicare Advantage plans with a star rating of four or higher (out of five) are eligible for a quality bonus in their basic premium rates. CMS continues to change its rating system to make achieving and maintaining a four or higher star rating more difficult. Our star ratings and past performance scores are adversely affected by the compliance issues that arise each year in our Medicare operations. If our star ratings fall below

four for a significant portion of our Medicare Advantage membership or do not match the performance of our competitors or the star rating quality bonuses are reduced or eliminated, our revenues, operating results and cash flows may be significantly adversely affected.

- Payments we receive from CMS for our Medicare Advantage and Medicare Part D businesses also are subject to risk adjustment based on the health status of the individuals we enroll. Elements of that risk adjustment mechanism continue to be challenged by the DOJ, the OIG and CMS itself. Substantial changes in the risk adjustment mechanism, including changes that result from enforcement or audit actions, could materially affect the amount of our Medicare reimbursement, require us to raise prices or reduce the benefits we offer to Medicare beneficiaries, and potentially limit our (and the industry's) participation in the Medicare program.
- Changes to the ability of PBMs to have pharmacy performance programs in place for clients and report payments via direct and indirect reporting mechanisms could impact the Pharmacy Services business.
- Medicare Part D has resulted in increased utilization of prescription medications and puts pressure on our pharmacy gross margin rates due to regulatory and competitive pressures. Further, as a result of the ACA and changes to the retiree drug subsidy rules, clients of our PBM business could decide to discontinue providing prescription drug benefits to their Medicare-eligible members. To the extent this phenomenon occurs, the adverse effects of increasing customer migration into Medicare Part D may outweigh the benefits we realize from growth of our Medicare Part D products.
- Our Medicare Part D operating results and our ability to expand our Medicare Part D business could be adversely affected if: the cost and complexity of Medicare Part D exceed management's expectations or prevent effective program implementation or administration; changes to the regulations regarding how drug costs are reported for Medicare Part D are implemented in a manner that adversely affects the profitability of our Medicare Part D business; changes to the applicable regulations impact our ability to retain fees from third parties including network pharmacies; the government alters Medicare Part D program requirements or reduces funding because of the higher-than-anticipated cost to taxpayers of Medicare Part D or for other reasons; the government mandated use of point-of-sale manufacturer's rebates effective in 2022 continues; the government enacts price controls on certain pharmaceutical products in Medicare Part D; the government makes changes to how pharmacy pay-for-performance is calculated; or reinsurance thresholds are reduced below their current levels.
- We have experienced challenges in obtaining complete and accurate encounter data for our Medicaid products due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could affect the Medicaid premium rates we receive and how Medicaid membership is assigned to us, which could have a material adverse effect on our Medicaid operating results and cash flows and/or our ability to bid for, and continue to participate in, certain Medicaid programs.
- If we fail to report and correct errors discovered through our own auditing procedures or during a CMS audit or otherwise fail to comply with the applicable laws and regulations, we could be subject to fines, civil monetary penalties or other sanctions, including fines and penalties under the False Claims Act, which could have a material adverse effect on our ability to participate in Medicare Advantage, Medicare Part D or other government programs, and on our operating results, cash flows and financial condition.
- Certain of our Medicaid contracts require the submission of complete and correct encounter data. The accurate and timely reporting of encounter data is increasingly important to the success of our Medicaid programs because more states are using encounter data to determine compliance with performance standards and, in part, to set premium rates. We have expended and may continue to expend additional effort and incur significant additional costs to collect accurate, or to correct inaccurate or incomplete, encounter data and have been and could be exposed to premium withholding, operating sanctions and financial fines and penalties for noncompliance. We have experienced challenges in obtaining complete and accurate encounter data due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could affect the Medicaid premium rates we receive and how Medicaid membership is assigned to us, which could have a material adverse effect on our Medicaid operating results and cash flows and/or our ability to successfully bid for, and continue to participate in, certain Medicaid programs.

Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues, and we expect that percentage to increase.

Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues, and we expect that percentage to increase. As our government funded businesses grow, our exposure to changes in federal and state government policy with respect to and/or regulation of the various government funded programs in which we participate also increases.

The laws and regulations governing participation in Medicare Advantage (including dual eligible special needs plans), Medicare Part D, Medicaid, and managed Medicaid plans are complex, are subject to interpretation and can expose us to penalties for non-compliance. Federal, state and local governments have the right to cancel or not to renew their contracts with

us on short notice without cause or if funds are not available. Funding for these programs is dependent on many factors outside our control, including general economic conditions, continuing government efforts to contain health care costs and budgetary constraints at the federal or applicable state or local level and general political issues and priorities.

The U.S. federal government and our other government customers also may reduce funding for health care or other programs, cancel or decline to renew contracts with us, or make changes that adversely affect the number of persons eligible for certain programs, the services provided to enrollees in such programs, our premiums and our administrative and health care and other benefit costs, any of which could have a material adverse effect on our businesses, operating results and cash flows. When federal funding is delayed, suspended or curtailed, we continue to receive, and we remain liable for and are required to fund, claims from providers for providing services to beneficiaries of federally funded health benefits programs in which we participate. An extended federal government shutdown or a delay by Congress in raising the federal government's debt ceiling also could lead to a delay, reduction, suspension or cancellation of federal government spending and a significant increase in interest rates that could, in turn, have a material adverse effect on the value of our investment portfolio, our ability to access the capital markets and our businesses, operating results, cash flows and liquidity.

Possible changes in industry pricing benchmarks and drug pricing generally can adversely affect our PBM and Retail/LTC businesses.

It is possible that the pharmaceutical industry, regulators, or federal policymakers may evaluate and/or develop an alternative pricing reference to replace AWP or WAC, which are the pricing references used for many of our PBM and LTC client contracts, drug purchase agreements, retail network contracts, specialty payor agreements and other contracts with third party payors in connection with the reimbursement of drug payments. In addition, many state Medicaid fee-for-service programs have established pharmacy network payments on the basis of Actual Acquisition Cost ("AAC"). The use of an AAC basis in fee for service Medicaid could have an impact on reimbursement practices in Health Care Benefits' Commercial and other Government products. It is also possible that Congress may enact some limited form of price negotiation for Medicare. In addition, CMS also publishes the National Average Drug Acquisition Cost ("NADAC") for certain drugs; NADAC pricing is being adopted in an increasing number of states.

Future changes to the use of AWP, WAC or to other published pricing benchmarks used to establish drug pricing, including changes in the basis for calculating reimbursement by federal and state health care programs and/or other payors, could impact the reimbursement we receive from Medicare and Medicaid programs, the reimbursement we receive from our PBM clients and other payors and/or our ability to negotiate rebates and/or discounts with drug manufacturers, wholesalers, PBMs and retail pharmacies. A failure or inability to fully offset any increased prices or costs or to modify our operations to mitigate the impact of such increases could have a material adverse effect on our operating results. Additionally, any future changes in drug prices could be significantly different than our projections. We cannot predict the effect of these possible changes on our businesses.

We may not be able to obtain adequate premium rate increases in our Insured Health Care Benefits products, which would have an adverse effect on our revenues, MBRs and operating results and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes.

Premium rates for our Insured Health Care Benefits products generally must be filed with state insurance regulators and are subject to their approval, which creates risk for us in the current political and regulatory environment. The ACA generally requires a review by HHS in conjunction with state regulators of premium rate increases that exceed a federally specified threshold (or lower state-specific thresholds set by states determined by HHS to have adequate processes). Rate reviews can magnify the adverse impact on our operating margins, MBRs and operating results of increases in health care and other benefit costs, increased utilization of covered services, and ACA assessments, fees and taxes, by restricting our ability to reflect these increases and/or these assessments, fees and taxes in our pricing. Further, our ability to reflect ACA assessments, fees and taxes in our Medicare, Medicaid and CHIP premium rates is limited.

Since 2013, HHS has issued determinations to health plans that their premium rate increases were "unreasonable," and we continue to experience challenges to appropriate premium rate increases in certain states. Regulators or legislatures in several states have implemented or are considering limits on premium rate increases, either by

enforcing existing legal requirements more stringently or proposing different regulatory standards. Regulators or legislatures in several states also have conducted hearings on proposed premium rate increases, which can result, and in some instances have resulted, in substantial delays in implementing proposed rate increases even if they ultimately are approved. Our plans can be excluded from participating in small group Public Exchanges if they are deemed to have a history of "unreasonable" rate increases. Any significant rate increases we may request heighten the risks of adverse publicity, adverse regulatory action and adverse selection and the

likelihood that our requested premium rate increases will be denied, reduced or delayed, which could adversely affect our MBRs and lead to operating margin compression.

We anticipate continued regulatory and legislative action to increase regulation of premium rates in our Insured Health Care Benefits products. We may not be able to obtain rates that are actuarially justified or that are sufficient to make our policies profitable in one or more product lines or geographies. If we are unable to obtain adequate premium rates and/or premium rate increases, it could materially and adversely affect our operating margins and MBRs and our ability to earn adequate returns on Insured Health Care Benefits products in one or more states or cause us to withdraw from certain geographies and/or products.

Minimum MLR rebate requirements limit the level of margin we can earn in our Insured Health Care Benefits products while leaving us exposed to higher than expected medical costs. Challenges to our minimum MLR rebate methodology and/or reports could adversely affect our operating results.

The ACA's minimum MLR rebate requirements limit the level of margin we can earn in Health Care Benefits' Commercial Insured and Medicare Insured businesses. CMS minimum MLR rebate regulations limit the level of margin we can earn in our Medicaid Insured business. Certain portions of our Health Care Benefits Medicaid and FEHB program business also are subject to minimum MLR rebate requirements in addition to but separate from those imposed by the ACA. Minimum MLR rebate requirements leave us exposed to medical costs that are higher than those reflected in our pricing. The process supporting the management and determination of the amount of MLR rebates payable is complex and requires judgment, and the minimum MLR reporting requirements are detailed. CMS has also proposed, but not yet finalized, a definition of "prescription drug price concessions" for commercial MLR calculation purposes, which would make additional PBM information available to plans and the HHS, potentially further complicating the MLR calculation process. Federal and state auditors are challenging our Commercial Health Care Benefits business' compliance with the ACA's minimum MLR requirements as well as our FEHB plans' compliance with OPM's FEHB program-specific minimum MLR requirements. Our Medicare and Medicaid contracts also are subject to minimum MLR audits. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS. Additional challenges to our methodology and/or reports relating to minimum MLR and related rebates by federal and state regulators and private litigants are reasonably possible. The outcome of these audits and additional challenges could adversely affect our operating results.

Our operating results may be adversely affected by changes in laws and policies governing employers and by union organizing activity.

Congress and certain state legislatures continue to consider and pass legislation that increases our costs of doing business, including increased minimum wages and requiring employers to provide paid sick leave or paid family leave. In addition, our employee-related operating costs may be increased by union organizing activity and it is possible that the National Labor Relations Board may adopt regulatory changes through re-making or case law that could facilitate union organizing. If we are unable to reflect these increased expenses in our pricing or otherwise modify our operations to mitigate the effects of such increases, our operating results will be adversely affected.

We face international political, legal and compliance, operational, regulatory, economic and other risks that may be more significant than in our domestic operations.

Our international operations present political, legal, compliance, operational, regulatory, economic and other risks that we do not face or that are more significant than in our domestic operations. These risks vary widely by country and include varying regional and geopolitical business conditions and demands, government intervention and censorship, discriminatory regulation, climate change regulation, nationalization or expropriation of assets and pricing constraints. Our international products need to meet country-specific customer and member preferences as well as country-specific legal requirements, including those related to licensing, data privacy, data storage and data protection.

Our international operations increase our exposure to, and require us to devote significant management resources to implement controls and systems to comply with, the privacy and data protection laws of non-U.S. jurisdictions, such as the EU's GDPR, and the anti-bribery, anti-corruption and anti-money laundering laws of the United States

(including the FCPA) and the United Kingdom (including the UK Bribery Act) and similar laws in other jurisdictions. Implementing our compliance policies, internal controls and other systems upon our expansion into new countries and geographies may require the investment of considerable management time and financial and other resources over several years before any significant revenues or profits are generated. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or employees, restrictions or outright prohibitions on the conduct of our business, and significant brand and reputational harm. We

must regularly reassess the size, capability and location of our global infrastructure and make appropriate changes, and must have effective change management processes and internal controls in place to address changes in our businesses and operations. Our success depends, in part, on our ability to anticipate these risks and manage these difficulties, and the failure to do so could have a material adverse effect on our brand, reputation, businesses, operating results and/or financial condition.

Our international operations require us to overcome logistical and other challenges based on differing languages, cultures, legal and regulatory schemes and time zones. Our international operations encounter labor laws, standards and customs that can be difficult and make employee relationships less flexible than in our domestic operations and expensive to modify or terminate. In some countries we are required to, or choose to, operate with local business associates, which requires us to manage our relationships with these third parties and may reduce our operational flexibility and ability to quickly respond to business challenges.

In some countries we may be exposed to currency exchange controls or other restrictions that prevent us from transferring funds internationally or converting local currencies into U.S. dollars or other currencies. Fluctuations in foreign currency exchange rates may adversely affect our revenues, operating results and cash flows from our international operations. Some of our operations are, and are increasingly likely to be, in emerging markets where these risks are heightened. Any measures we may implement to reduce the effect of volatile currencies and other risks on our international operations may not be effective.

Risks Associated with Mergers, Acquisitions, and Divestitures

We may be unable to successfully integrate companies we acquire.

Upon the closing of any acquisition we complete, we will need to successfully integrate the products, services and related assets, as well as internal controls into our business operations. If an acquisition is consummated, the integration of the acquired business, its products, services and related assets into our company also may be complex and time-consuming and, if the integration is not fully successful, we may not achieve the anticipated benefits, operating and cost synergies and/or growth opportunities of an acquisition. Potential difficulties that may be encountered in the integration process include the following:

- Integrating personnel, operations and systems (including internal control environments and compliance policies), while maintaining focus on producing and delivering consistent, high quality products and services;
- Coordinating geographically dispersed organizations;
- Disrupting management's attention from our ongoing business operations;
- Retaining existing customers and attracting new customers;
- Managing inefficiencies associated with integrating our operations; and
- Reconciling post-acquisition costs and liabilities between buyer and seller.

An inability to realize the full extent of the anticipated benefits, operating and cost synergies, innovations and operations efficiencies or growth opportunities of an acquisition, as well as any delays or additional expenses encountered in the integration process, could have a material adverse effect on our businesses and operating results. Furthermore, acquisitions, even if successfully integrated, may fail to further our business strategy as anticipated, expose us to increased competition or challenges with respect to our products, services or service areas, and expose us to additional liabilities associated with an acquired business including risks and liabilities associated with litigation involving the acquired business. Any one of these challenges or risks could impair our ability to realize any benefit from our acquisitions after we have expended resources on them.

We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities, which may be unsuccessful, cause us to assume unanticipated liabilities, disrupt our existing businesses, be dilutive or lead us to assume significant debt, among other things.

We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities as part of our growth strategy. In addition to the integration risks noted above, some other risks we face with respect to acquisitions and other inorganic growth strategies include:

- we frequently compete with other firms, some of which may have greater financial and other resources and a greater tolerance for risk, to acquire attractive companies;
- the acquired, alliance and/or joint venture businesses may not perform as projected;

- the goodwill or other intangible assets established as a result of our acquisitions may be incorrectly valued or may become impaired;
- we may assume unanticipated liabilities, including those that were not disclosed to us or which we underestimated;
- the acquired businesses, or the pursuit of other inorganic growth strategies, could disrupt or compete with our existing businesses, distract management, result in the loss of key employees, divert resources, result in tax costs or inefficiencies and make it difficult to maintain our current business standards, controls, information technology systems, policies, procedures and performance;
- we may finance future acquisitions and other inorganic growth strategies by issuing common stock for some or all of the purchase price, which would dilute the ownership interests of our stockholders;
- we may incur significant debt in connection with acquisitions (whether to finance acquisitions or by assuming debt from the businesses we acquire);
- we may not have the expertise to manage and profitably grow the businesses we acquire, and we may need to rely on the retention of key personnel and other suppliers of businesses we acquire, which may be difficult or impossible to accomplish;
- we may enter into merger or purchase agreements but, due to reasons within or outside our control, fail to complete the related transactions, which could result in termination fees or other penalties that could be material, cause material disruptions to our businesses and operations and adversely affect our brand and reputation;
- in order to complete a proposed acquisition, we may be required to divest certain portions of our business, for which we may not be able to obtain favorable pricing;
- we may be involved in litigation related to mergers or acquisitions, including for matters that occurred prior to the applicable closing, which may be costly to defend and may result in adverse rulings against us that could be material; and
- the integration into our businesses of the businesses and entities we acquire may affect the way in which existing laws and regulations apply to us, including subjecting us to laws and regulations that did not previously apply to us.

In addition, joint ventures present risks that are different from acquisitions, including selection of appropriate joint venture parties, initial and ongoing governance of the joint venture, joint venture compliance activities (including compliance with applicable CMS requirements), growing the joint venture's business in a manner acceptable to all the parties, including other providers in the networks that include joint ventures, maintaining positive relationships among the joint venture parties and the joint venture's customers, and member and business disruption that may occur upon joint venture termination.

Risks Related to Our Operations

Failure to meet customer expectations may harm our brand and reputation, our ability to retain and grow our customer base and membership and our operating results and cash flows.

Our ability to attract and retain customers and members is dependent upon providing cost effective, quality customer service operations (such as call center operations, PBM functions, retail pharmacy and LTC services, retail, mail order and specialty pharmacy prescription delivery, claims processing, customer case installation and online access and tools) that meet or exceed our customers' and members' expectations, either directly or through vendors. As we seek to reduce general and administrative expenses, we must balance the potential impact of cost-saving measures on our customers and other services and performances. If we misjudge the effects of such measures, customers and other services may be adversely affected. We depend on third parties for certain of our customer service, PBM and prescription delivery operations. If we or our vendors fail to provide service that meets our customers' and members' expectations, we may have difficulty retaining or profitably growing our customer base and/or membership, which could adversely affect our operating results. For example, noncompliance with any privacy or security laws or regulations or any security breach involving us or one of our third-party vendors could have a material adverse effect on our businesses, operating results, brand and reputation.

We and our vendors have experienced and continue to experience cyber attacks. We can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future.

We and our vendors have experienced diverse cyber attacks and expect to continue to experience cyber attacks going forward. As examples, the Company and its vendors have experienced attempts to gain access to systems, denial of service attacks, attempted malware infections, account takeovers, scanning activity, and phishing emails. Attacks can originate from external criminals, terrorists, nation states, or internal actors. The Company is dedicating and will continue to dedicate significant resources and incur significant expenses to maintain and update on an ongoing basis the systems and processes that are

designed to mitigate the information security risks it faces and protect the security of its computer systems, software, networks and other technology assets against attempts by unauthorized parties to obtain access to confidential information, disrupt or degrade service, or cause other damage. The impact of cyber attacks has not been material to the Company's operations or operating results through December 31, 2021. The Board and its Audit Committee and Nominating and Corporate Governance Committee are regularly informed regarding the Company's information security policies, practices and status.

A compromise of our information security controls or of those businesses with whom we interact, which results in confidential information being accessed, obtained, damaged, or used by unauthorized or improper persons, could harm our reputation and expose us to regulatory actions and claims from customers and clients, financial institutions, payment card associations and other persons, any of which could adversely affect our businesses, operating results and financial condition. Because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may not immediately produce signs of intrusion, we may be unable to anticipate these techniques or to implement adequate preventative measures. Moreover, a data security breach could require that we expend significant resources related to our information systems and infrastructure, and could distract management and other key personnel from performing their primary operational duties. We also could be adversely affected by any significant disruption in the systems of third parties we interact with, including key payors and vendors.

The costs of attempting to protect against the foregoing risks and the costs of responding to an information security incident are significant. Large scale data breaches at other entities increase the challenge we and our vendors face in maintaining the security of our information technology systems and proprietary information and of our customers', members' and other constituents' sensitive information. Following an information security incident, our and/or our vendors' remediation efforts may not be successful, and could result in interruptions, delays or cessation of service, and loss of existing or potential customers and members. In addition, breaches of our and/or our vendors' security measures and the unauthorized access to or dissemination of sensitive personal information or proprietary information or confidential information about us, our customers, our members or other third-parties, could expose our customers', members' and other constituents' private information and our customers, members and other constituents to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, and result in investigations, regulatory enforcement actions, material fines and penalties, loss of customers, litigation or other actions which could have a material adverse effect on our brand, reputation, businesses, operating results and cash flows.

Data governance failures can adversely affect our reputation, businesses and prospects. Our use and disclosure of members', customers' and other constituents' sensitive information is subject to complex regulations at multiple levels. We would be adversely affected if we or our business associates or other vendors fail to adequately protect members', customers' or other constituents' sensitive information.

Our information systems are critical to the operation of our businesses. We collect, process, maintain, retain, evaluate, utilize and distribute large amounts of personal health and financial information and other confidential and sensitive data about our customers, members and other constituents in the ordinary course of our businesses. Some of our information systems rely upon third party systems, including cloud service providers, to accomplish these tasks. The use and disclosure of such information is regulated at the federal, state and international levels, and these laws, rules and regulations are subject to change and increased enforcement activity, such as the California Consumer Privacy Act which went into effect January 1, 2020, the EU's GDPR which began to apply across the EU during 2018 and the audit program implemented by HHS under HIPAA. In some cases, such laws, rules and regulations also apply to our vendors and/or may hold us liable for any violations by our vendors. International laws, rules and regulations governing the use and disclosure of such information are generally more stringent than U.S. laws and regulations, and they vary from jurisdiction to jurisdiction. Noncompliance with any privacy or security laws or regulations, or any security breach, information security incident, and any other incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, sensitive or confidential customer, member or other constituent information, whether by us, by one of our business associates or vendors or by another third party, could require us to expend significant resources to remediate any damage, could interrupt our operations and could adversely affect our brand and reputation, membership and operating results and also could expose and/or has exposed us to mandatory disclosure to the media, litigation (including class action litigation), governmental investigations and enforcement proceedings, material fines, penalties and/or remediation costs, and compensatory, special, punitive and statutory damages, consent orders, adverse actions against our licenses to do business and/or

injunctive relief, any of which could adversely affect our businesses, operating results, cash flows or financial condition.

Our businesses depend on our customers', members' and other constituents' willingness to entrust us with their health related and other sensitive personal information. Events that adversely affect that trust, including inadequate disclosure to our members or customers of our uses of their information, failing to keep our information technology systems and our customers', members'

and other constituents' sensitive information secure from significant attack, theft, damage, loss or unauthorized disclosure or access, whether as a result of our action or inaction (including human error) or that of our business associates, vendors or other third parties, could adversely affect our brand and reputation, membership and operating results and also could expose and/or has exposed us to mandatory disclosure to the media, litigation (including class action litigation), governmental investigations and enforcement proceedings, material fines, penalties and/or remediation costs, and compensatory, special, punitive and statutory damages, consent orders, adverse actions against our licenses to do business and/or injunctive relief, any of which could adversely affect our businesses, operating results, cash flows or financial condition. Large scale data breaches at other entities increase the challenge we and our vendors face in maintaining the security of our information technology systems and proprietary information and of our customers', members' and other constituents' sensitive information. There can be no assurance that additional such failures will not occur, or if any do occur, that we will detect them or that they can be sufficiently remediated.

Product liability, product recall or personal injury issues could damage our reputation and have a significant adverse effect on our businesses, operating results, cash flows and/or financial condition.

The products that we sell could become subject to contamination, product tampering, mislabeling, recall or other damage. In addition, errors in the dispensing, packaging or administration of drugs or other products and consuming drugs in a manner that is not prescribed could lead to serious injury or death. Product liability or personal injury claims may be asserted against us with respect to any of the drugs or other products we sell or services we provide. For example, we are a defendant in hundreds of litigation proceedings relating to opioids and the sale of products containing talc. Our businesses involve the provision of professional services, including by pharmacists, physician assistants, nurses and nurse practitioners, which exposes us to professional liability claims. Should a product or other liability issue arise, the coverage available under our insurance programs and the indemnification amounts available to us from third parties may not be adequate to protect us against the financial impact of the related claims. We also may not be able to maintain our existing levels of insurance on acceptable terms in the future. A product liability or personal injury issue or judgment against us or a product recall, tampering, or mislabeling could damage our reputation and have a significant adverse effect on our businesses, operating results and/or financial condition.

We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success, and our failure to do so could adversely affect our businesses, operating results and/or future performance.

Our ability to attract and retain qualified and experienced employees is essential to meet our current and future goals and objectives. There is no guarantee we will be able to attract and retain such employees or that competition among potential employers will not result in increased compensation and/or benefits costs. If we are unable to retain existing employees or attract additional employees, or we experience an unexpected loss of leadership, we could experience a material adverse effect on our businesses, operating results and/or future performance.

In addition, our failure to adequately plan for succession of senior management and other key management roles or the failure of key employees to successfully transition into new roles could have a material adverse effect on our businesses, operating results and/or future performance. The succession plans we have in place and our employment arrangements with certain key executives do not guarantee the services of these executives will continue to be available to us.

Sales of our products and services are dependent on our ability to attract and motivate internal sales personnel and independent third-party brokers, consultants and agents. New distribution channels create new disintermediation risk. We may be subject to penalties or other regulatory actions as a result of the marketing practices of brokers and agents selling our products.

Our products are sold primarily through our sales personnel, who frequently work with independent brokers, consultants and agents who assist in the production and servicing of business. The independent brokers, consultants and agents generally are not dedicated to us exclusively and may frequently recommend and/or market health care benefits products of our competitors. Accordingly, we must compete intensely for their services and allegiance. Our sales could be adversely affected if we are unable to attract, retain or motivate sales personnel and third-party brokers, consultants and agents, or if we do not adequately provide support, training and education to this sales network regarding our complex product portfolio, or if our sales strategy is not appropriately aligned across distribution channels. This risk is heightened as we develop, operate and expand our consumer-oriented products and

services and we expand in the health care space and our business model evolves to include a greater focus on consumers and direct-to-consumer sales, such as competing for sales on Insurance Exchanges.

New distribution channels for our products and services continue to emerge, including Private Exchanges operated by health care consultants and technology companies. These channels may make it more difficult for us to directly engage consumers and other customers in the selection and management of their health care benefits, in health care utilization and in the effective navigation of the health care system. We also may be challenged by new technologies and marketplace entrants that could interfere with our existing relationships with customers and health plan members in these areas.

In addition, there have been several investigations regarding the marketing practices of brokers and agents selling health care and other insurance products and the payments they receive. These investigations have resulted in enforcement actions against companies in our industry and brokers and agents marketing and selling those companies' products. For example, CMS and state departments of insurance have increased their scrutiny of the marketing practices of brokers and agents who market Medicare products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans and/or changes to industry practices, which could adversely affect our ability to market our products.

Failure of our businesses to effectively collaborate could prevent us from maximizing our operating results.

To maximize our overall enterprise value, our various businesses need to collaborate effectively. Our businesses need to be aligned in order to prioritize goals and coordinate the design of new products intended to utilize the offerings of multiple businesses, including our transformation and enterprise modernization programs. In addition, misaligned incentives, information siloes, ineffective product development and failure of our corporate governance policies or procedures, for example significant financial decisions being made at an inappropriate level in our organization, also could prevent us from maximizing our operating results and/or achieving our financial and other projections.

The failure or disruption of our information technology systems or the failure of our information technology infrastructure to support our businesses could adversely affect our reputation, businesses, operating results and cash flows.

Our information systems are subject to damage or interruption from power outages, facility damage, computer and telecommunications failures, computer viruses, security breaches (including credit card or personally identifiable information breaches), cyber attacks, vandalism, catastrophic events and human error. If our information systems are damaged, fail to work properly or otherwise become unavailable, we may incur substantial costs to repair or replace them, and may experience reputational damage, loss of critical information, customer disruption and interruptions or delays in our ability to perform essential functions and implement new and innovative services. In addition, compliance with changes in U.S. and foreign laws and regulations, including privacy and information security laws and standards, may cause us to incur significant expense due to increased investment in technology and the development of new operational processes.

Our business success and operating results depend in part on effective information technology systems and on continuing to develop and implement improvements in technology. Pursuing multiple initiatives simultaneously could make this continued development and implementation significantly more challenging.

Many aspects of our operations are dependent on our information systems and the information collected, processed, stored, and handled by these systems. We rely heavily on our computer systems to manage our ordering, pricing, point-of-sale, pharmacy fulfillment, inventory replenishment, claims processing, customer loyalty and subscription programs, finance and other processes. Throughout our operations, we collect, process, maintain, retain, evaluate, utilize and distribute large amounts of confidential and sensitive data and information, including personally identifiable information and protected health information, that our customers, members and other constituents provide to purchase products or services, enroll in programs or services, register on our websites, interact with our personnel, or otherwise communicate with us. In addition, for these operations, we depend in part on the secure transmission of confidential information over public networks.

We have many different information and other technology systems supporting our businesses (including as a result of our acquisitions). Our businesses depend in large part on these systems to adequately price our products and services; accurately establish reserves, process claims and report operating results; and interact with providers, employer plan sponsors, customers, members, consumers and vendors in an efficient and uninterrupted fashion. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more

sophisticated applications for mobile devices. Certain of our technology systems (including software) are older, legacy systems that are less flexible, less efficient and require a significant ongoing commitment of capital and human resources to maintain, protect and enhance them and to integrate them with our other systems. We must re-engineer and reduce the number of these systems to meet changing consumer and vendor preferences and needs, improve our productivity and reduce our operating expenses. We also need to develop or acquire new technology systems, contract with new vendors or modify certain of our existing systems to support the consumer-oriented and transformation products and services we are developing, operating and expanding and/or to meet current

and developing industry and regulatory standards, including to keep pace with continuing changes in information processing technology and emerging cybersecurity risks and threats. If we fail to achieve these objectives, our ability to profitably grow our business and/or our operating results may be adversely affected.

In addition, information technology and other technology and process improvement projects, including our transformation and enterprise modernization programs, frequently are long-term in nature and may take longer to complete and cost more than we expect and may not deliver the benefits we project once they are complete. If we do not effectively and efficiently secure, manage, integrate and enhance our technology portfolio (including vendor sourced systems), we could, among other things, have problems determining health care and other benefit cost estimates and/or establishing appropriate pricing, meeting the needs of customers, consumers, providers, members and vendors, developing and expanding our consumer-oriented products and services or keeping pace with industry and regulatory standards, and our operating results may be adversely affected.

We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.

We accept payments using a variety of methods, including cash, checks, credit cards, debit cards, gift cards, mobile payments and potentially other technologies in the future. Acceptance of these payment methods subjects us to rules, regulations, contractual obligations and compliance requirements, including payment network rules and operating guidelines, data security standards and certification requirements, and rules governing electronic funds transfers. These requirements may change in the future, which could make compliance more difficult or costly. For certain payment options, including credit and debit cards, we pay interchange and other fees, which could increase periodically thereby raising our operating costs. We rely on third parties to provide payment processing services, including the processing of credit cards, debit cards, and various other forms of electronic payment. If these vendors are unable to provide these services to us, or if their systems are compromised, our operations could be disrupted. The payment methods that we offer also expose us to potential fraud and theft by persons seeking to obtain unauthorized access to, or exploit any weaknesses in, the payment systems we use. If we fail to abide by applicable rules or requirements, or if data relating to our payment systems is compromised due to a breach or misuse, we may be responsible for any costs incurred by payment card issuing banks and other third parties or subject to fines and higher transaction fees. In addition, our reputation and ability to accept certain types of payments could each be harmed resulting in reduced sales and adverse effects on our operating results.

Both our and our vendors' operations are subject to a variety of business continuity hazards and risks, any of which could interrupt our operations or otherwise adversely affect our performance and operating results.

We and our vendors are subject to business continuity hazards and other risks, including natural disasters, utility and other mechanical failures, acts of war or terrorism, acts of civil unrest, disruption of communications, data security and preservation, disruption of supply or distribution, safety regulation and labor difficulties. The occurrence of any of these or other events to us or our vendors might disrupt or shut down our operations or otherwise adversely affect our operations. We also may be subject to certain liability claims in the event of an injury or loss of life, or damage to property, resulting from such events. Although we have developed procedures for crisis management and disaster recovery and business continuity plans and maintain insurance policies that we believe are customary and adequate for our size and industry, our insurance policies include limits and exclusions and, as a result, our coverage may be insufficient to protect against all potential hazards and risks incident to our businesses. In addition, our crisis management and disaster recovery procedures and business continuity plans may not be effective. Should any such hazards or risks occur, or should our insurance coverage be inadequate or unavailable, our businesses, operating results, cash flows and financial condition could be adversely affected.

Financial Risks

We would be adversely affected if we do not effectively deploy our capital. Downgrades or potential downgrades in our credit ratings, should they occur, could adversely affect our brand and reputation, businesses, operating results, cash flows and financial condition.

Our operations generate significant capital, and we have the ability to raise additional capital. The manner in which we deploy our capital, including investments in our businesses, our operations (such as information technology and other strategic and capital projects), dividends, acquisitions, share and/or debt repurchases, repayment of debt,

reinsurance or other capital uses, impacts our financial strength, claims paying ability and credit ratings issued by nationally-recognized statistical rating organizations. Credit ratings issued by nationally-recognized statistical rating organizations are broadly distributed and generally used throughout our industries. Our ratings reflect each rating organization's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to our insureds. We believe our credit ratings and

the financial strength and claims paying ability of our principal insurance and HMO subsidiaries are important factors in marketing our Health Care Benefits products to certain of our customers.

Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future. Downgrades in our ratings could adversely affect our businesses, operating results, cash flows and financial condition.

Goodwill and other intangible assets could, in the future, become impaired.

As of December 31, 2021 and December 31, 2020, we had $108.1 billion and $110.7 billion, respectively, of goodwill and other intangible assets. Goodwill and indefinite-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable. When evaluating goodwill for potential impairment, we compare the fair value of our reporting units to their respective carrying amounts. We estimate the fair value of our reporting units using a combination of a discounted cash flow method and a market multiple method. If the carrying amount of a reporting unit exceeds its estimated fair value, a goodwill impairment loss is recognized in an amount equal to the excess to the extent of the goodwill balance. Indefinite-lived intangible assets are tested for impairment by comparing the estimated fair value of the asset to its carrying value. The Company estimates the fair value of its indefinite-lived trademarks using the relief from royalty method under the income approach. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized, and the asset is written down to its estimated fair value. Definite-lived intangible assets are tested for impairment whenever events or changes in circumstances indicate that the carrying value of such an asset may not be recoverable. If indicators of impairment are present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted). If the estimated future cash flows used in this analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group's estimated future cash flows (discounted).

Estimated fair values could change if, for example, there are changes in the business climate, industry-wide changes, changes in the competitive environment, adverse legal or regulatory actions or developments, changes in capital structure, cost of debt, interest rates, capital expenditure levels, operating cash flows or market capitalization. Because of the significance of our goodwill and intangible assets, any future impairment of these assets could require material noncash charges to our operating results, which also could have a material adverse effect on our financial condition.

Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative investments and other investments, and our operating results and/or our financial condition.

The global capital markets, including credit markets, continue to experience volatility and uncertainty. As an insurer, we have a substantial investment portfolio that supports our policy liabilities and surplus and is comprised largely of debt securities of issuers located in the U.S. As a result, the income we earn from our investment portfolio is largely driven by the level of interest rates in the U.S., and to a lesser extent the international financial markets; and volatility, uncertainty and/or disruptions in the global capital markets, particularly the U.S. credit markets, and governments' monetary policy, particularly U.S. monetary policy, can significantly and adversely affect the value of our investment portfolio, our operating results and/or our financial condition by:

- significantly reducing the value and/or liquidity of the debt securities we hold in our investment portfolio and creating realized capital losses that reduce our operating results and/or unrealized capital losses that reduce our shareholders' equity;
- keeping interest rates low on high-quality short-term or medium-term debt securities (such as we have experienced during recent years) and thereby materially reducing our net investment income and operating results as the proceeds from securities in our investment portfolio that mature or are otherwise disposed of continue to be reinvested in lower yielding securities;
- reducing the fair values of our investments if interest rates rise;
- causing non-performance of or defaults on their obligations to us by third parties, including customers, issuers of securities in our investment portfolio, mortgage borrowers and/or reinsurance and/or derivatives counterparties;

- making it more difficult to value certain of our investment securities, for example if trading becomes less frequent, which could lead to significant period-to-period changes in our estimates of the fair values of those securities and cause period-to-period volatility in our net income and shareholders' equity;

- reducing our ability to issue short-term debt securities at attractive interest rates, thereby increasing our interest expense and decreasing our operating results; and
- reducing our ability to issue other securities.

Although we seek, within guidelines we deem appropriate, to match the duration of our assets and liabilities and to manage our credit and counterparty exposures, a failure adequately to do so could adversely affect our net income and our financial condition and, in extreme circumstances, our cash flows.

Risks Related to Our Relationships with Manufacturers, Providers, Suppliers and Vendors

We face risks relating to the market availability, pricing, suppliers and safety profiles of prescription drugs and other products that we purchase and sell.

Our Retail/LTC segment and our mail order and specialty pharmacy operations generate revenues in significant part by dispensing prescription drugs. Our PBM business generates revenues primarily by contracting with clients to provide prescription drugs and related health care services to plan members. As a result, we are dependent on our relationships with prescription drug manufacturers and suppliers. We acquire a substantial amount of our mail order and specialty pharmacies' prescription drug supply from a limited number of suppliers. Certain of our agreements with such suppliers are short-term and cancelable by either party without cause. In addition, these agreements may allow the supplier to distribute through channels other than us. Certain of these agreements also allow pricing and other terms to be adjusted periodically for changing market conditions or required service levels. A termination or modification to any of these relationships could adversely affect our prescription drug supply and have a material adverse effect on our businesses, operating results and financial condition. Moreover, many products distributed by our pharmacies are manufactured with ingredients that are susceptible to supply shortages. In some cases, we depend upon a single source of supply. Any such supply shortages or loss of any such single source of supply could adversely affect our operating results and cash flows.

Much of the branded and generic drug product that we sell in our pharmacies, and much of the other merchandise we sell, is manufactured in whole or in substantial part outside of the United States. In most cases, the products or merchandise are imported by others and sold to us. As a result, significant changes in tax or trade policies, tariffs or trade relations between the United States and other countries, such as the imposition of unilateral tariffs on imported products, could result in significant increases in our costs, restrict our access to suppliers, depress economic activity, and have a material adverse effect on our businesses, operating results and cash flows. In addition, other countries may change their business and trade policies and such changes, as well as any negative sentiments towards the United States in response to increased import tariffs and other changes in U.S. trade regulations, could adversely affect our businesses.

Our suppliers are independent entities subject to their own operational and financial risks that are outside our control. If our current suppliers were to stop selling prescription drugs to us or delay delivery, including as a result of supply shortages, supplier production disruptions, supplier quality issues, closing or bankruptcies of our suppliers, or for other reasons, we may be unable to procure alternatives from other suppliers in a timely and efficient manner and on acceptable terms, or at all.

Our operating results may be adversely affected if we are unable to contract with providers on competitive terms and develop and maintain attractive networks with high quality providers.

We are seeking to enhance our health care provider networks by entering into joint ventures and other collaborative risk-sharing arrangements with providers. Providers' willingness to enter these arrangements with us depends upon, among other things, our ability to provide them with up to date quality of care data to support these value-based contracts. These arrangements are designed to give providers incentives to engage in population health management and optimize delivery of health care to our members. These arrangements also may allow us to expand into new geographies, target new customer groups, increase membership and reduce medical costs and, if we provide technology or other services to the relevant health system or provider organization, may contribute to our revenue and earnings from alternative sources. If such arrangements do not result in the lower medical costs that we project or if we fail to attract providers to such arrangements, or are less successful at implementing such arrangements than our competitors, our medical costs may not be competitive and may be higher than we project, our attractiveness to

customers may be reduced, we may lose or be unable to grow medical membership, and our ability to profitably grow our business and/or our operating results may be adversely affected.

While we believe joint ventures, accountable care organizations ("ACOs") and other non-traditional health care provider organizational structures present opportunities for us, the implementation of our joint ventures and other non-traditional structure strategies may not achieve the intended results, which could adversely affect our operating results and cash flows.

Among other things, joint ventures require us to maintain collaborative relationships with our counterparties, continue to gain access to provider rates that make the joint ventures economically sustainable and devote significant management time to the operation and management of the joint ventures. We may not be able to achieve these objectives in one or more of our joint ventures, which could adversely affect our operating results and cash flows.

If our suppliers or service providers fail to meet their contractual obligations to us or to comply with applicable laws or regulations, we may be exposed to brand and reputational harm, litigation and/or regulatory action. This risk is particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs.

In addition to our suppliers, we contract with various third parties to perform certain functions and services and provide us with certain information technology systems. Our arrangements with suppliers and these third parties may expose us to public scrutiny, adversely affect our brand and reputation, expose us to litigation or regulatory action, and otherwise make our operations vulnerable if we fail to adequately oversee, monitor and regulate their performance or if they fail to meet their contractual obligations to us or to comply with applicable laws or regulations, including those related to human capital and climate change. For example, certain of our vendors have been responsible for releases of sensitive information of our members and employees, which has caused us to incur additional expenses and given rise to regulatory actions and litigation against us.

These risks are particularly high in our in Medicare Advantage (including dual eligible special needs plans), Medicare Part D, Medicaid, and managed Medicaid plans, where third parties may perform medical management and other member related services for us. Any failure of our or these third parties' prevention, detection or control systems related to regulatory compliance, compliance with our internal policies, data security and/or cybersecurity or any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, members', customers' or other constituents' sensitive information could require us to expend significant resources to remediate any damage, interrupt our operations and adversely affect our brand and reputation and also expose us to whistleblower, class action and other litigation, other proceedings, prohibitions on marketing or active or passive enrollment of members, corrective actions, fines, sanctions and/or penalties, any of which could adversely affect our businesses, operating results, cash flows and/or financial condition.

We may experience increased medical and other benefit costs, litigation risk and customer and member dissatisfaction when providers that do not have contracts with us render services to our Health Care Benefits members.

Some providers that render services to our Health Care Benefits members do not have contracts with us. In those cases, we do not have a pre-established understanding with these providers as to the amount of compensation that is due to them for services rendered to our members. In some states, the amount of compensation due to these nonparticipating providers is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover the difference between what we have paid them and the amount they charged us from our members, which may result in customer and member dissatisfaction. For example, in October 2018, an arbitrator awarded certain claimant hospitals approximately $150 million in a proceeding relating to Aetna's out-of-network benefit payment and administration practices, and in March 2019 that award was reduced to approximately $86 million. Such disputes may cause us to pay higher medical or other benefit costs than we projected.

Continuing consolidation and integration among providers and other suppliers may increase our medical and other covered benefits costs, make it difficult for us to compete in certain geographies and create new competitors.

Hospitals and other providers and health systems continue to consolidate across the health care industry. While this consolidation could increase efficiency and has the potential to improve the delivery of health care services, it also reduces competition and the number of potential contracting parties in certain geographies. These health systems also are increasingly forming and considering forming health plans to directly offer health insurance in competition with us, a process that has been accelerated by the ACA. In addition, ACOs (including Commercial and Medicaid-only ACOs developed as a result of state Medicaid laws), practice management companies, consolidation among and by integrated health systems and other changes in the organizational structures that physicians, hospitals and other providers adopt continues to change the way these providers interact with us and the competitive landscape in which we operate. These changes may increase our medical and other covered benefits costs, may affect the way we price

our products and services and estimate our medical and other covered benefits costs and may require us to change our operations, including by withdrawing from certain geographies where we do not have a significant presence across our businesses or are unable to collaborate or contract with providers on acceptable terms. Each of these changes may adversely affect our businesses and operating results.

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Item 1B. Unresolved Staff Comments.

There are no unresolved SEC Staff Comments.

Item 2. Properties.

The Company's principal office is an owned building complex located in Woonsocket, Rhode Island, which totals approximately one million square feet. The Company also leases office space in other locations in the United States.

Health Care Benefits Segment

The Health Care Benefits segment's principal office is an owned building complex located in Hartford, Connecticut, which totals approximately 1.7 million square feet. The Health Care Benefits segment also owns or leases office space in other locations in the United States and several other countries.

Pharmacy Services Segment

The Pharmacy Services segment includes owned or leased mail service dispensing pharmacies, call centers, on-site pharmacy stores, retail specialty pharmacy stores, specialty mail service pharmacies and branches for infusion and enteral services throughout the United States.

Retail/LTC Segment

As of December 31, 2021, the Retail/LTC segment operated the following properties:

- Approximately 8,075 retail stores, of which approximately 5% were owned. Net selling space for retail stores was approximately 79.8 million square feet as of December 31, 2021.
- Approximately 1,865 retail pharmacies within retail chains, as well as approximately 80 clinics in Target Corporation ("Target") stores;
- Owned distribution centers and leased distribution facilities throughout the United States totaling approximately 10.7 million square feet; and
- Owned and leased LTC pharmacies throughout the United States and an owned LTC repackaging facility.

In connection with certain business dispositions completed between 1995 and 1997, the Company continues to guarantee lease obligations for 72 former stores. The Company is indemnified for these guarantee obligations by the respective initial purchasers. These guarantees generally remain in effect for the initial lease term and any extension thereof pursuant to a renewal option provided for in the lease prior to the time of the disposition. For additional information on these guarantees, see "Lease Guarantees" in Note 16 ''Commitments and Contingencies'' included in Item 8 of this 10-K.

Management believes that the Company's owned and leased facilities are suitable and adequate to meet the Company's anticipated needs. At the end of the existing lease terms, management believes the leases can be renewed or replaced by alternative space. For additional information on the right-of-use assets and lease liabilities associated with the Company's leases, see Note 6 ''Leases'' included in Item 8 of this 10-K.

Item 3. Legal Proceedings.

The information contained in Note 16 ''Commitments and Contingencies'' included in Item 8 of this 10-K is incorporated herein by reference.

Item 4. Mine Safety Disclosures.

Not applicable.

Information about our Executive Officers

The following sets forth the name, age and biographical information for each of the Registrant's executive officers as of February 9, 2022. In each case the officer's term of office extends to the date of the meeting of the Board following the next annual meeting of stockholders of CVS Health Corporation. Previous positions and responsibilities held by each of the executive officers over the past five years or more are indicated below:

Troyen A. Brennan, M.D., age 67, Executive Vice President and Chief Medical Officer of CVS Health Corporation since November 2008; Executive Vice President and Chief Medical Officer of Aetna Inc. from February 2006 through November 2008.

James D. Clark, age 57, Senior Vice President - Controller and Chief Accounting Officer of CVS Health Corporation since November 2018; Vice President - Finance and Accounting of CVS Pharmacy, Inc. from September 2009 through October 2018.

Daniel P. Finke, age 51, Executive Vice President of CVS Health Corporation and President of Health Care Benefits since February 2021; Executive Vice President, Commercial Business and Markets of Aetna Inc. from February 2020 through January 2021; Executive Vice President, Consumer Health and Service of Aetna Inc. from June 2018 through January 2020; Senior Vice President, Network and Clinical Services of Aetna Inc. from January 2016 through May 2018.

Shawn M. Guertin, age 58, Executive Vice President and Chief Financial Officer of CVS Health Corporation since May 2021; Executive Vice President, Chief Financial Officer and Chief Enterprise Risk Officer of Aetna Inc. from February 2013 through May 2019; Senior Vice President, Finance of Aetna Inc. from April 2011 through January 2013.

Laurie P. Havanec, age 61, Executive Vice President and Chief People Officer of CVS Health Corporation since February 2021; Executive Vice President and Chief People Officer, Otis Worldwide Corporation, an elevator, escalator and moving walkway manufacturer, from October 2019 through January 2021; Corporate Vice President, Talent of United Technologies Corporation, a multinational manufacturing conglomerate, from April 2017 through October 2019; Vice President - Human Resources, Institution Businesses of Aetna Inc. from 2013 through March 2017.

Alan M. Lotvin, M.D., age 60, Executive Vice President of CVS Health Corporation and President of CVS Caremark since March 2020; Executive Vice President - Transformation of CVS Health Corporation from June 2018 through February 2020; Executive Vice President - Specialty Pharmacy, CVS Caremark from November 2012 through May 2018.

Karen S. Lynch, age 59, President and Chief Executive Officer of CVS Health Corporation since February 2021; Executive Vice President of CVS Health Corporation from November 2018 through January 2021; President of Aetna Inc. from January 2015 through January 2021; and a director of CVS Health Corporation since February 2021. Ms. Lynch is also a member of the board of directors of U.S. Bancorp, a banking and financial services company.

Thomas M. Moriarty, age 58, Executive Vice President and General Counsel of CVS Health Corporation since October 2012; Chief Policy and External Affairs Officer since March 2017; Chief Strategy Officer from March 2014 through February 2017.

Michelle A. Peluso, age 49, Executive Vice President and Chief Customer Officer of CVS Health Corporation since January 2021 and Co-President of Retail since January 2022; Senior Vice President, Digital Sales and Chief Marketing Officer, IBM, a multinational technology corporation, from February 2016 through January 2021; Chief Executive Officer, Gilt Groupe, Inc., an online shopping destination, from 2013 through February 2016. Ms. Peluso is also a member of the board of directors of Nike, Inc., an athletic footwear and clothing manufacturer.

Jonathan C. Roberts, age 66, Executive Vice President and Chief Operating Officer of CVS Health Corporation since March 2017; Executive Vice President of CVS Health Corporation and President of CVS Caremark from September 2012 through February 2017.

Prem Shah, age 42, Executive Vice President and Chief Pharmacy Officer of CVS Health Corporation since November 2021 and Co-President of Retail since January 2022; Executive Vice President, Specialty and Product Innovation , CVS Caremark from August 2018 through November 2021; Vice President - Specialty Pharmacy, CVS Caremark from February 2013 through July 2018.

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PART II

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

Market Information

CVS Health Corporation's common stock is listed on the New York Stock Exchange under the symbol "CVS."

Dividends

During 2021, 2020 and 2019, the quarterly cash dividend was $0.50 per share. In December 2021, the Board authorized a 10% increase in the quarterly cash dividend to $0.55 per share effective in 2022. CVS Health Corporation has paid cash dividends every quarter since becoming a public company. Future dividends will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

See Note 12 ''Shareholders' Equity'' included in Item 8 of this 10-K for information regarding CVS Health Corporation's dividends.

Holders of Common Stock

As of February 2, 2022, there were 24,946 registered holders of the registrant's common stock according to the records maintained by the registrant's transfer agent.

Issuer Purchases of Equity Securities

The following share repurchase programs have been authorized by the Board:

In billions **Authorization Date**	**Authorized**	**Remaining as of December 31, 2021**
December 9, 2021 ("2021 Repurchase Program")	$ 10.0	$ 10.0
November 2, 2016 ("2016 Repurchase Program")	15.0	—

Each of the share Repurchase Programs was effective immediately. The 2016 Repurchase program was terminated effective December 9, 2021. The 2021 Repurchase Program permits the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase ("ASR") transactions, and/or other derivative transactions. The 2021 Repurchase Program can be modified or terminated by the Board at any time. During the three months ended December 31, 2021, the Company did not repurchase any shares of common stock.

Pursuant to the authorization under the 2021 Repurchase Program, the Company entered into a $1.5 billion fixed dollar ASR with Barclays Bank PLC ("Barclays"). Upon payment of the $1.5 billion purchase price on January 4, 2022, the Company received a number of shares of CVS Health Corporation's common stock equal to 80% of the $1.5 billion notional amount of the ASR or approximately 11.6 million shares at a price of $103.34 per share, which were placed into treasury stock in January 2022. At the conclusion of the ASR, the Company may receive additional shares equal to the remaining 20% of the $1.5 billion notional amount. The ultimate number of shares the Company may receive will depend on the daily volume-weighted average price of the Company's stock over an averaging period, less a discount. It is also possible, depending on such weighted average price, that the Company will have an obligation to Barclays which, at the Company's option, could be settled in additional cash or by issuing shares. Under the terms of the ASR, the maximum number of shares that could be delivered to the Company is 29.0 million.

See Note 12 ''Shareholders' Equity'' included in Item 8 of this 10-K for additional information regarding the Company's share repurchases.

Stock Performance Graph

The following graph compares the cumulative total shareholder return on CVS Health Corporation's common stock (assuming reinvestment of dividends) with the cumulative total return on the S&P 500 Index, the S&P 500 Food and Staples Retailing Industry Group Index and the S&P 500 Healthcare Sector Group Index from December 31, 2016 through December 31, 2021. The graph assumes a $100 investment in shares of CVS Health Corporation's common stock on December 31, 2016.

	December 31,					
	2016	2017	2018	2019	2020	2021
CVS Health Corporation	$ 100	$ 94	$ 88	$ 103	$ 97	$ 151
S&P 500 [1]	100	122	116	153	181	233
S&P 500 Food & Staples Retailing Group Index [2]	100	113	115	146	170	213
S&P 500 Health Care Group Index [1] [3]	100	122	130	157	178	225

(1) Includes CVS Health Corporation.
(2) Includes five companies (COST, KR, SYY, WBA, WMT).
(3) Includes 64 companies.

The year-ended values of each investment shown in the preceding graph are based on share price appreciation plus dividends, with the dividends reinvested as of the last business day of the month during which such dividends were ex-dividend. The calculations exclude trading commissions and taxes. Total shareholder returns from each investment can be calculated from the year-end investment values shown beneath the graph.

Item 6. Reserved

Not applicable.

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Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations. ("MD&A")

The following discussion and analysis should be read in conjunction with the audited consolidated financial statements and related notes included in Item 8 of this Annual Report on Form 10-K (this "10-K"), "Risk Factors" included in Item 1A of this 10-K and the "Cautionary Statement Concerning Forward-Looking Statements" in this 10-K.

Overview of Business

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is a diversified health solutions company united around a common purpose of helping people on their path to better health. In an increasingly connected and digital world, we are meeting people wherever they are and changing health care to meet their needs. The Company has more than 9,900 retail locations, nearly 1,200 walk-in medical clinics, a leading pharmacy benefits manager with approximately 110 million plan members with expanding specialty pharmacy solutions and a dedicated senior pharmacy care business serving more than one million patients per year. The Company also serves an estimated 35 million people through traditional, voluntary and consumer-directed health insurance products and related services, including expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

The Company has four reportable segments: Health Care Benefits, Pharmacy Services, Retail/LTC and Corporate/ Other, which are described below.

Overview of the Health Care Benefits Segment

The Health Care Benefits segment operates as one of the nation's leading diversified health care benefits providers. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make more informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental and behavioral health plans, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services, and health information technology products and services. The Health Care Benefits segment also provided workers' compensation administrative services through its Coventry Health Care Workers' Compensation business ("Workers' Compensation business") prior to the sale of this business on July 31, 2020. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates. The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk for medical and dental care costs) as "ASC." In addition, effective January 2022, the Company entered the individual public health insurance exchanges ("Public Exchanges") in eight states through which it sells Insured plans directly to individual consumers.

Overview of the Pharmacy Services Segment

The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services and mail order pharmacy. In addition, through the Pharmacy Services segment, the Company provides specialty pharmacy and infusion services, clinical services, disease management services, medical spend management and pharmacy and/or other administrative services for providers and federal 340B drug pricing program covered entities ("Covered Entities"). The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Medicaid managed care plans, plans offered on Public Exchanges and private health insurance exchanges, other sponsors of health benefit plans throughout the United States and Covered Entities. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services.

Overview of the Retail/LTC Segment

The Retail/LTC segment sells prescription drugs and a wide assortment of health and wellness products and general merchandise, provides health care services through its MinuteClinic® walk-in medical clinics, provides medical diagnostic testing, administers vaccinations for illnesses such as influenza, coronavirus disease 2019 ("COVID-19") and shingles and conducts long-term care pharmacy ("LTC") operations, which distribute prescription drugs and provide related pharmacy

consulting and other ancillary services to long-term care facilities and other care settings. As of December 31, 2021, the Retail/LTC segment operated more than 9,900 retail locations, nearly 1,200 MinuteClinic locations as well as online retail pharmacy websites, LTC pharmacies and onsite pharmacies. For the year ended December 31, 2021, the Company dispensed approximately 26.4% of the total retail pharmacy prescriptions in the United States.

Overview of the Corporate/Other Segment

The Company presents the remainder of its financial results in the Corporate/Other segment, which primarily consists of:

- Management and administrative expenses to support the Company's overall operations, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments, expenses associated with the Company's investments in its transformation and enterprise modernization programs and acquisition-related integration costs; and
- Products for which the Company no longer solicits or accepts new customers such as large case pensions and long-term care insurance products.

COVID-19

The COVID-19 pandemic and its emerging new variants continue to impact the U.S. and other countries around the world. Our strong local presence and scale in communities across the country has enabled us to continue to play an indispensable role in the national response to COVID-19, as well as provide seamless support for our customers wherever they need us: in our CVS locations, in their homes, and virtually. The COVID-19 pandemic had a significant impact on the Company's operating results for the years ended December 31, 2021 and 2020, primarily in the Company's Health Care Benefits and Retail/LTC segments.

Health Care Benefits Segment

Beginning in mid-March 2020, the health system experienced a significant reduction in utilization of medical services ("utilization") that is discretionary and the cancellation of elective medical procedures. Utilization remained below historical levels through April 2020, began to recover in May and June 2020 and reached more normal levels in the third and fourth quarters of 2020, with select geographies impacted by COVID-19 waves. In response to COVID-19, the Company provided expanded benefit coverage to its members, including cost-sharing waivers for COVID-19 related treatments, as well as assistance to members through premium credits, telehealth cost-sharing waivers and other investments. During 2020, COVID-19 also resulted in a shift in the Company's medical membership. The Company experienced declines in Commercial membership due to reductions in workforce at our existing customers, substantially offset by increases in Medicaid membership primarily as a result of the suspension of eligibility redeterminations and increased unemployment.

During the year ended December 31, 2021, overall medical costs in the first quarter were generally consistent with historical baseline levels in the aggregate, however the segment experienced increased COVID-19 testing and treatment costs and lower Medicare risk-adjusted revenue. During the second quarter, COVID-19 testing and treatment costs persisted, however at levels significantly lower than those observed during the first quarter. Beginning in the third quarter of 2021, medical costs once again increased primarily driven by the spread of emerging new variants of COVID-19, which resulted in increased testing and treatment costs throughout the remainder of the year.

Retail/LTC Segment

During March 2020, the Company experienced increased prescription volume due to the greater use of 90-day prescriptions and early refills of maintenance medications, as well as increased front store volume as consumers prepared for the COVID-19 pandemic. Beginning in the second quarter and continuing throughout the remainder of the year, the Company experienced reduced customer traffic in its retail pharmacies and MinuteClinic locations due to shelter-in-place orders as well as reduced new therapy prescriptions and decreased long-term care prescription volume as a result of the COVID-19 pandemic. In addition, the Company incurred incremental operating expenses associated with the Company's COVID-19 pandemic response efforts and waived fees associated with prescription home delivery and associated front store products. During 2020, the Company also played a key role in supporting the local communities in which it operates through the administration of diagnostic testing at its CVS Pharmacy® locations, as well as in long-term care facilities, at community-based testing sites in underserved areas and through its Return Ready℠ solution. The Company also began administering COVID-19 vaccinations in long-term care facilities during December 2020.

During the first quarter of 2021, the Company experienced reduced customer traffic in its retail pharmacies, which reflected the impact of a weak cough, cold and flu season, while it administered the highest quarterly volume of COVID-19 diagnostic tests. The Company began administering COVID-19 vaccines in its retail pharmacies during February 2021. During the second quarter, the segment generated earnings from COVID-19 vaccines and saw improved customer traffic as vaccinated customers began more actively shopping in CVS locations. During the third and fourth quarters, emerging new variants drove the continued administration of COVID-19 vaccinations (including boosters) and diagnostic testing, while the segment also generated earnings from the sale of over-the-counter ("OTC") test kits in the front store. During the year ended December 31, 2021, the Company administered more than 32 million COVID-19 tests and more than 59 million COVID-19 vaccines and sold more than 22 million OTC test kits.

The COVID-19 pandemic continues to evolve. We believe COVID-19's impact on our businesses, operating results, cash flows and/or financial condition primarily will be driven by the geographies impacted and the severity and duration of the pandemic; the pandemic's impact on the U.S. and global economies and consumer behavior and health care utilization patterns; and the timing, scope and impact of stimulus legislation as well as other federal, state and local governmental responses to the pandemic. Those primary drivers are beyond our knowledge and control. As a result, the impact COVID-19 will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be adverse and material.

Results of Operations

The following information summarizes the Company's results of operations for 2021 compared to 2020. For discussion of the Company's results of operations for 2020 compared to 2019, see "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2020 filed with the U.S. Securities and Exchange Commission (the "SEC") on February 16, 2021.

Summary of Consolidated Financial Results

				Change			
	Year Ended December 31,			2021 vs. 2020		2020 vs. 2019	
In millions	**2021**	**2020**	**2019**	**$**	**%**	**$**	**%**
Revenues:							
Products	$203,738	$190,688	$185,236	$13,050	6.8 %	$ 5,452	2.9 %
Premiums	76,132	69,364	63,122	6,768	9.8 %	6,242	9.9 %
Services	11,042	7,856	7,407	3,186	40.6 %	449	6.1 %
Net investment income	1,199	798	1,011	401	50.3 %	(213)	(21.1)%
Total revenues	292,111	268,706	256,776	23,405	8.7 %	11,930	4.6 %
Operating costs:							
Cost of products sold	175,803	163,981	158,719	11,822	7.2 %	5,262	3.3 %
Benefit costs	64,260	55,679	52,529	8,581	15.4 %	3,150	6.0 %
Store impairments	1,358	—	231	1,358	100.0 %	(231)	(100.0)%
Goodwill impairment	431	—	—	431	100.0 %	—	— %
Operating expenses	37,066	35,135	33,310	1,931	5.5 %	1,825	5.5 %
Total operating costs	278,918	254,795	244,789	24,123	9.5 %	10,006	4.1 %
Operating income	13,193	13,911	11,987	(718)	(5.2)%	1,924	16.1 %
Interest expense	2,503	2,907	3,035	(404)	(13.9)%	(128)	(4.2)%
Loss on early extinguishment of debt	452	1,440	79	(988)	(68.6)%	1,361	1,722.8 %
Other income	(182)	(206)	(124)	24	11.7 %	(82)	(66.1)%
Income before income tax provision	10,420	9,770	8,997	650	6.7 %	773	8.6 %
Income tax provision	2,522	2,569	2,366	(47)	(1.8)%	203	8.6 %
Income from continuing operations	7,898	7,201	6,631	697	9.7 %	570	8.6 %
Loss from discontinued operations, net of tax	—	(9)	—	9	100.0 %	(9)	(100.0)%
Net income	7,898	7,192	6,631	706	9.8 %	561	8.5 %
Net (income) loss attributable to noncontrolling interests	12	(13)	3	25	192.3 %	(16)	(533.3)%
Net income attributable to CVS Health	$ 7,910	$ 7,179	$ 6,634	$ 731	10.2 %	$ 545	8.2 %

Commentary - 2021 compared to 2020

Revenues

- Total revenues increased $23.4 billion or 8.7% in 2021 compared to 2020. The increase in total revenues was primarily driven by growth across all segments.
- Please see "Segment Analysis" later in this MD&A for additional information about the revenues of the Company's segments.

Operating expenses

- Operating expenses increased $1.9 billion or 5.5% in 2021 compared to 2020. The increase in operating expenses was primarily due to incremental costs associated with growth in the business, including costs associated with the administration of COVID-19 vaccinations and diagnostic testing in the Retail/LTC segment. The increase in operating expenses was partially offset by the repeal of the non-deductible health insurer fee ("HIF") for 2021 and gains from anti-trust legal settlements of $263 million recorded in 2021.

- Operating expenses as a percentage of total revenues decreased to 12.7% in 2021 compared to 13.1% in 2020. The decrease in operating expenses as a percentage of total revenues was primarily due to the increases in total revenues referred to above.
- Please see "Segment Analysis" later in this MD&A for additional information about the operating expenses of the Company's segments.

Operating income
- Operating income decreased $718 million or 5.2% in 2021 compared to 2020. The decrease in operating income was primarily due to:
    - A store impairment charge of approximately $1.4 billion recorded in the fourth quarter of 2021 related to planned retail store closures over the next three years;
    - Decreased operating income in the Health Care Benefits segment, driven by higher COVID-19 related costs in 2021 compared to the prior year, including the impact of the deferral of elective procedures and other discretionary utilization in response to the COVID-19 pandemic during 2020, as well as the absence of pre-tax income of $307 million associated with the receipt of amounts owed to the Company under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA") risk corridor program ("ACA risk corridor receipt"); and
    - A $431 million goodwill impairment charge associated with the LTC business in the Retail/LTC segment recorded during the third quarter of 2021, partially offset by:
    - Increased prescription and front store volume and the administration of COVID-19 vaccinations and diagnostic testing in the Retail/LTC segment;
    - Improved purchasing economics and growth in specialty pharmacy in the Pharmacy Services segment;
    - Gains from anti-trust legal settlements of $263 million recorded in 2021; and
    - Lower acquisition-related integration costs in 2021 compared to the prior year.
- Please see "Segment Analysis" later in this MD&A for additional information about the operating income of the Company's segments.

Interest expense
- Interest expense decreased $404 million in 2021 compared to 2020, due to lower debt in the year ended December 31, 2021. See "Liquidity and Capital Resources" later in this report for additional information.

Loss on early extinguishment of debt
- During 2021, the loss on early extinguishment of debt relates to the Company's repayment of approximately $2.3 billion of its outstanding senior notes in December 2021 pursuant to its early redemption make-whole provision for such senior notes, which resulted in a loss on early extinguishment of debt of $89 million, and the repayment of approximately $2.0 billion of its outstanding senior notes pursuant to its tender offer for such notes in August 2021, which resulted in a loss on early extinguishment of debt of $363 million. During 2020, the loss on early extinguishment of debt relates to the Company's repayment of $6.0 billion of its outstanding senior notes pursuant to its tender offers for such senior notes in August 2020, which resulted in a loss on early extinguishment of debt of $766 million, and the repayment of $4.5 billion of its outstanding senior notes pursuant to its tender offers for such senior notes in December 2020, which resulted in a loss on early extinguishment of debt of $674 million. See Note 8 ''Borrowings and Credit Agreements'' included in Item 8 of this 10-K for additional information.

Income tax provision
- The Company's effective income tax rate decreased to 24.2% in 2021 compared to 26.3% in the prior year primarily due to the repeal of the non-deductible HIF for 2021 and the favorable impact of a prior year refund claim approved by the Internal Revenue Service during the fourth quarter of 2021. The decrease was partially offset by the absence of the favorable resolution of certain tax matters in the fourth quarter of 2020.

Loss from discontinued operations
- In connection with certain business dispositions completed between 1995 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Linens 'n Things and Bob's Stores, each of which subsequently filed for bankruptcy. The Company's loss from discontinued operations in 2020 primarily included lease-related costs required to satisfy these lease guarantees.

- See “Discontinued Operations” in Note 1 ‘‘Significant Accounting Policies’’ and “Lease Guarantees” in Note 16 ‘‘Commitments and Contingencies’’ included in Item 8 of this 10-K for additional information about the Company’s discontinued operations and the Company’s lease guarantees, respectively.

Outlook for 2022

With respect to 2022, the Company believes you should consider the following important information:

- The Health Care Benefits segment is expected to benefit from Medicare and Commercial membership growth, partially offset by membership declines in its Medicaid products. The projected MBR is expected to decrease compared to 2021, reflecting a combination of expected improved pricing and a reduction in COVID-19 related medical costs. While the Company still expects a net negative impact from COVID-19 in 2022 within the Health Care Benefits segment, the expectation is the impact will be less adverse than what was experienced in 2021.
- The Pharmacy Services segment is expected to benefit from the Company's ability to drive further improvements in purchasing economics and continued growth in specialty pharmacy, partially offset by continued price compression and state regulation of pharmacy pricing.
- The Retail/LTC segment is expected to continue to benefit from increased prescription volume and improved generic drug purchasing, partially offset by continued pharmacy reimbursement pressure and incremental operating expenses associated with the Company's minimum wage investment. The Company expects that COVID-19 vaccinations and diagnostic testing will continue in 2022, albeit at lower levels than those experienced during 2021. The Company expects to see continued strength in Front Store sales, including sales of OTC test kits, in 2022. The extent of COVID-19 vaccinations, diagnostic testing and OTC test kit sales will be dependent upon various factors including vaccine hesitancy, the emergence of new variants, government testing initiatives and the availability and administration of pediatric and booster vaccinations.
- The Company is expected to benefit from the continuation of its enterprise-wide cost savings initiatives, which aim to reduce the Company's operating cost structure in a way that improves the consumer experience and is sustainable. Key drivers include:
    - Investments in digital, technology and analytics capabilities that will streamline processes and improve outcomes,
    - Implementing workforce and workplace strategies, and
    - Deploying vendor and procurement strategies.
- The Company expects changes to its business environment to continue as elected and other government officials at the national and state levels continue to propose and enact significant modifications to public policy and existing laws and regulations that govern or impact the Company's businesses.
- The COVID-19 pandemic continues to impact the economies of the U.S. and other countries around the world. The Company believes COVID-19's impact on its businesses, operating results, cash flows and/or financial condition primarily will be driven by the geographies impacted and the severity and duration of the pandemic, as well as the pandemic's impact on the U.S. and global economies, global supply chain, consumer behavior, and health care utilization patterns. In addition, as described in the "Government Regulation" section of this Form 10-K, federal, state and local governmental policies and initiatives designed to reduce the transmission of COVID-19 and emerging new variants may not effectively combat the severity and/or duration of the COVID-19 pandemic, and have resulted in a myriad of impacts on the Company's businesses. Those primary drivers are beyond the Company's knowledge and control. As a result, the impact COVID-19 will have on the Company's businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be adverse and material.

The Company's current expectations described above are forward-looking statements. Please see "Risk Factors" included in Item 1A of this 10-K and the "Cautionary Statement Concerning Forward-Looking Statements" in this 10-K for information regarding important factors that may cause the Company's actual results to differ from those currently projected and/or otherwise materially affect the Company.

Segment Analysis

The following discussion of segment operating results is presented based on the Company's reportable segments in accordance with the accounting guidance for segment reporting and is consistent with the segment disclosure in Note 17 "Segment Reporting" included in Item 8 of this 10-K.

The Company has three operating segments, Health Care Benefits, Pharmacy Services and Retail/LTC, as well as a Corporate/Other segment. The Company's segments maintain separate financial information, and the Company's chief operating decision maker (the "CODM") evaluates the segments' operating results on a regular basis in deciding how to allocate resources among the segments and in assessing segment performance. The CODM evaluates the performance of the Company's segments based on adjusted operating income, which is defined as operating income (GAAP measure) excluding the impact of amortization of intangible assets and other items, if any, that neither relate to the ordinary course of the Company's business nor reflect the Company's underlying business performance. See the reconciliations of operating income (GAAP measure) to adjusted operating income below for further context regarding the items excluded from operating income in determining adjusted operating income. The Company uses adjusted operating income as its principal measure of segment performance as it enhances the Company's ability to compare past financial performance with current performance and analyze underlying business performance and trends. Non-GAAP financial measures the Company discloses, such as consolidated adjusted operating income, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

The following is a reconciliation of financial measures of the Company's segments to the consolidated totals:

In millions	**Health Care Benefits**	**Pharmacy Services [1]**	**Retail/ LTC**	**Corporate/ Other**	**Intersegment Eliminations [2]**	**Consolidated Totals**
2021						
Total revenues	$ 82,186	$ 153,022	$ 100,105	$ 721	$ (43,923)	$ 292,111
Adjusted operating income (loss)	5,012	6,859	7,623	(1,471)	(711)	17,312
2020						
Total revenues	75,467	141,938	91,198	426	(40,323)	268,706
Adjusted operating income (loss)	6,188	5,688	6,146	(1,306)	(708)	16,008
2019						
Total revenues	69,604	141,491	86,608	512	(41,439)	256,776
Adjusted operating income (loss)	5,202	5,129	6,705	(1,000)	(697)	15,339

(1) Total revenues of the Pharmacy Services segment include approximately $11.6 billion, $10.9 billion and $11.5 billion of retail co-payments for 2021, 2020 and 2019, respectively. See Note 1 "Significant Accounting Policies" included in Item 8 of this 10-K for additional information about retail co-payments.

(2) Intersegment revenue eliminations relate to intersegment revenue generating activities that occur between the Health Care Benefits segment, the Pharmacy Services segment, and/or the Retail/LTC segment. Intersegment adjusted operating income eliminations occur when members of Pharmacy Services Segment clients ("PSS members") enrolled in Maintenance Choice® elect to pick up maintenance prescriptions at one of the Company's retail pharmacies instead of receiving them through the mail. When this occurs, both the Pharmacy Services and Retail/LTC segments record the adjusted operating income on a stand-alone basis.

The following are reconciliations of consolidated operating income (GAAP measure) to consolidated adjusted operating income, as well as reconciliations of segment GAAP operating income to segment adjusted operating income:

	Year Ended December 31, 2021					
In millions	**Health Care Benefits**	**Pharmacy Services**	**Retail/ LTC**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Operating income (loss) (GAAP measure)	$ 3,521	$ 6,667	$ 5,322	$ (1,606)	$ (711)	$ 13,193
Amortization of intangible assets [1]	1,552	192	512	3	—	2,259
Acquisition-related integration costs [2]	—	—	—	132	—	132
Store impairments [3]	—	—	1,358	—	—	1,358
Goodwill impairment [4]	—	—	431	—	—	431
Acquisition purchase price adjustment outside of measurement period [5]	(61)	—	—	—	—	(61)
Adjusted operating income (loss)	$ 5,012	$ 6,859	$ 7,623	$ (1,471)	$ (711)	$ 17,312

	Year Ended December 31, 2020					
In millions	**Health Care Benefits**	**Pharmacy Services**	**Retail/ LTC**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Operating income (loss) (GAAP measure)	$ 5,166	$ 5,454	$ 5,640	$ (1,641)	$ (708)	$ 13,911
Amortization of intangible assets [1]	1,598	234	506	3	—	2,341
Acquisition-related integration costs [2]	—	—	—	332	—	332
Gain on divestiture of subsidiary [6]	(269)	—	—	—	—	(269)
Receipt of fully reserved ACA risk corridor receivable [7]	(307)	—	—	—	—	(307)
Adjusted operating income (loss)	$ 6,188	$ 5,688	$ 6,146	$ (1,306)	$ (708)	$ 16,008

	Year Ended December 31, 2019					
In millions	**Health Care Benefits**	**Pharmacy Services**	**Retail/ LTC**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Operating income (loss) (GAAP measure)	$ 3,639	$ 4,735	$ 5,793	$ (1,483)	$ (697)	$ 11,987
Amortization of intangible assets [1]	1,563	394	476	3	—	2,436
Acquisition-related integration costs [2]	—	—	—	480	—	480
Store impairments [3]	—	—	231	—	—	231
Loss on divestiture of subsidiary [6]	—	—	205	—	—	205
Adjusted operating income (loss)	$ 5,202	$ 5,129	$ 6,705	$ (1,000)	$ (697)	$ 15,339

(1) The Company's acquisition activities have resulted in the recognition of intangible assets as required under the acquisition method of accounting which consist primarily of trademarks, customer contracts/relationships, covenants not to compete, technology, provider networks and value of business acquired. Definite-lived intangible assets are amortized over their estimated useful lives and are tested for impairment when events indicate that the carrying value may not be recoverable. The amortization of intangible assets is reflected in the Company's GAAP consolidated statements of operations in operating expenses within each segment. Although intangible assets contribute to the

Company's revenue generation, the amortization of intangible assets does not directly relate to the underwriting of the Company's insurance products, the services performed for the Company's customers or the sale of the Company's products or services. Additionally, intangible asset amortization expense typically fluctuates based on the size and timing of the Company's acquisition activity. Accordingly, the Company believes excluding the amortization of intangible assets enhances the Company's and investors' ability to compare the Company's past financial performance with its current performance and to analyze underlying business performance and trends. Intangible asset amortization excluded from the related non-GAAP financial measure represents the entire amount recorded within the Company's GAAP financial statements, and the revenue generated by the associated intangible assets has not been excluded from the related non-GAAP financial measure. Intangible asset amortization is excluded from the related non-GAAP financial measure because the amortization, unlike the related revenue, is not affected by operations of any particular period unless an intangible asset becomes impaired or the estimated useful life of an intangible asset is revised.

(2) In 2021, 2020 and 2019, acquisition-related integration costs relate to the Company's acquisition ("Aetna Acquisition") of Aetna Inc. ("Aetna"). The acquisition-related integration costs are reflected in the Company's GAAP consolidated statements of operations in operating expenses within the Corporate/Other segment.

(3) During the year ended December 31, 2021, the store impairment charge relates to the write down of operating lease right-of-use assets and property and equipment in connection with the planned closure of approximately 900 retail stores between 2022 and 2024. During the year ended December 31, 2019, the store impairment charges related to the write down of operating lease right-of-use assets in connection with the planned closure of 68 underperforming retail pharmacy stores in 2019 and 2020. The store impairment charges are reflected in the Company's GAAP consolidated statements of operations within the Retail/LTC segment.

(4) During the year ended December 31, 2021, the goodwill impairment charge relates to the LTC reporting unit within the Retail/LTC segment.

(5) In June 2021, the Company received $61 million related to a purchase price working capital adjustment for an acquisition completed during the first quarter of 2020. The resolution of this matter occurred subsequent to the acquisition accounting measurement period and is reflected in the Company's GAAP consolidated statement of operations for the year ended December 31, 2021 as a reduction of operating expenses within the Health Care Benefits segment.

(6) In 2020, the gain on divestiture of subsidiary represents the pre-tax gain on the sale of the Workers' Compensation business, which the Company sold on July 31, 2020 for approximately $850 million. The gain on divestiture is reflected as a reduction of operating expenses in the Company's GAAP consolidated statement of operations within the Health Care Benefits segment. In 2019, the loss on divestiture of subsidiary represents the pre-tax loss on the sale of Onofre, which occurred on July 1, 2019. The loss on divestiture primarily relates to the elimination of the cumulative translation adjustment from accumulated other comprehensive income and is reflected in the Company's GAAP consolidated statement of operations in operating expenses within the Retail/LTC segment.

(7) In 2020, the Company received $313 million owed to it under the ACA's risk corridor program that was previously fully reserved for as payment was uncertain. After considering offsetting items such as the ACA's minimum medical loss ratio ("MLR") rebate requirements and premium taxes, the Company recognized pre-tax income of $307 million in the Company's GAAP consolidated statement of operations within the Health Care Benefits segment.

Health Care Benefits Segment

The following table summarizes the Health Care Benefits segment's performance for the respective periods:

	Year Ended December 31,			Change			
				2021 vs. 2020		2020 vs. 2019	
In millions, except percentages and basis points ("bps")	**2021**	**2020**	**2019**	**$**	**%**	**$**	**%**
Revenues:							
Premiums	$ 76,064	$ 69,301	$ 63,031	$ 6,763	9.8 %	$ 6,270	9.9 %
Services	5,536	5,683	5,974	(147)	(2.6)%	(291)	(4.9)%
Net investment income	586	483	599	103	21.3 %	(116)	(19.4)%
Total revenues	82,186	75,467	69,604	6,719	8.9 %	5,863	8.4 %
Benefit costs	64,662	56,083	53,092	8,579	15.3 %	2,991	5.6 %
MBR (Benefit costs as a % of premium revenues)	85.0 %	80.9 %	84.2%	410 bps		(330) bps	
Operating expenses	$ 14,003	$ 14,218	$ 12,873	$ (215)	(1.5)%	$ 1,345	10.4 %
Operating expenses as a % of total revenues	17.0 %	18.8 %	18.5 %				
Operating income	$ 3,521	$ 5,166	$ 3,639	$(1,645)	(31.8)%	$ 1,527	42.0 %
Operating income as a % of total revenues	4.3 %	6.8 %	5.2 %				
Adjusted operating income [(1)]	$ 5,012	$ 6,188	$ 5,202	$(1,176)	(19.0)%	$ 986	19.0 %
Adjusted operating income as a % of total revenues	6.1 %	8.2 %	7.5 %				
Premium revenues (by business):							
Government	$ 55,739	$ 48,928	$ 41,818	$ 6,811	13.9 %	$ 7,110	17.0 %
Commercial	20,325	20,373	21,213	(48)	(0.2)%	(840)	(4.0)%

(1) See "Segment Analysis" above in this MD&A for a reconciliation of operating income (GAAP measure) to adjusted operating income for the Health Care Benefits segment, which represents the Company's principal measure of segment performance.

Commentary - 2021 compared to 2020

Revenues

- Total revenues increased $6.7 billion, or 8.9%, to $82.2 billion in 2021 compared to 2020 primarily driven by growth in the Government Services business, partially offset by the unfavorable impact of the repeal of the HIF for 2021 and the absence of the ACA risk corridor receipt.

Medical Benefit Ratio ("MBR")

- Medical benefit ratio is calculated as benefit costs divided by premium revenues and represents the percentage of premium revenues spent on medical benefits for the Company's Insured members. Management uses MBR to assess the underlying business performance and underwriting of its insurance products, understand variances between actual results and expected results and identify trends in period-over-period results. MBR provides management and investors with information useful in assessing the operating results of the Company's Insured Health Care Benefits products.
- The MBR increased from 80.9% to 85.0% in 2021 compared to the prior year. The increase was primarily driven by higher COVID-19 related costs in 2021 compared to the prior year, including the impact of the deferral of elective procedures and other discretionary utilization in response to the COVID-19 pandemic during 2020 and the repeal of the HIF for 2021, partially offset by improved underlying performance in the current year.

Operating expenses

- Operating expenses in the Health Care Benefits segment include selling, general and administrative expenses and depreciation and amortization expenses.
- Operating expenses decreased $215 million, or 1.5%, in 2021 compared to 2020. The decrease in operating expenses was primarily due to the repeal of the HIF for 2021, partially offset by incremental operating expenses to support the growth in the Government Services business described above and the net impact of the sale of the Workers' Compensation business sold on July 31, 2020.

Adjusted operating income

- Adjusted operating income decreased $1.2 billion, or 19.0%, in 2021 compared to 2020. The decrease in adjusted operating income was primarily driven by higher COVID-19 related costs in 2021 compared to the prior year, including the impact of the deferral of elective procedures and other discretionary utilization in response to the COVID-19 pandemic during 2020. The decrease was partially offset by improved performance in the underlying Government Services business and higher favorable development of prior-years' health care cost estimates in 2021 compared to the prior year.

The following table summarizes the Health Care Benefits segment's medical membership as of December 31, 2021 and 2020:

	2021			2020		
In thousands	**Insured**	**ASC**	**Total**	**Insured**	**ASC**	**Total**
Medical membership:						
Commercial	3,258	13,530	16,788	3,258	13,644	16,902
Medicare Advantage	2,971	—	2,971	2,705	—	2,705
Medicare Supplement	1,285	—	1,285	1,082	—	1,082
Medicaid	2,333	471	2,804	2,100	623	2,723
Total medical membership	9,847	14,001	23,848	9,145	14,267	23,412
Supplemental membership information:						
Medicare Prescription Drug Plan (standalone)			5,777			5,490

Medical Membership

- Medical membership represents the number of members covered by the Company's Insured and ASC medical products and related services at a specified point in time. Management uses this metric to understand variances between actual medical membership and expected amounts as well as trends in period-over-period results. This metric provides management and investors with information useful in understanding the impact of medical membership on segment total revenues and operating results.
- Medical membership as of December 31, 2021 of 23.8 million increased 436,000 compared with December 31, 2020, primarily reflecting increases in Medicare and Medicaid products, partially offset by declines in Commercial self-insured membership.

Medicare Update

On January 15, 2021, the U.S. Centers for Medicare & Medicaid Services ("CMS") issued its final notice detailing final 2022 Medicare Advantage benchmark payment rates. Final 2022 Medicare Advantage rates resulted in an increase in industry benchmark rates of approximately 4.1%.

The ACA ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star ratings." Plans must have a star rating of four or higher (out of five) to qualify for bonus payments. CMS released the Company's 2022 star ratings in October 2021. The Company's 2022 star ratings will be used to determine which of the Company's Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2023. Based on the Company's membership at December 31, 2021, 87% of the Company's Medicare Advantage members were in plans with 2022 star ratings of at least 4.0 stars, compared to 83% of the Company's Medicare Advantage members being in plans with 2021 star ratings of at least 4.0 stars based on the Company's membership at December 31, 2020.

Pharmacy Services Segment

The following table summarizes the Pharmacy Services segment's performance for the respective periods:

				Change			
	Year Ended December 31,			2021 vs. 2020		2020 vs. 2019	
In millions, except percentages	**2021**	**2020**	**2019**	**$**	**%**	**$**	**%**
Revenues:							
Products	$151,851	$140,950	$140,946	$ 10,901	7.7 %	$ 4	— %
Services	1,171	988	545	183	18.5 %	443	81.3 %
Total revenues	153,022	141,938	141,491	11,084	7.8 %	447	0.3 %
Cost of products sold	144,894	135,045	135,245	9,849	7.3 %	(200)	(0.1)%
Operating expenses	1,461	1,439	1,511	22	1.5 %	(72)	(4.8)%
Operating expenses as a % of total revenues	1.0 %	1.0 %	1.1 %				
Operating income	$ 6,667	$ 5,454	$ 4,735	$ 1,213	22.2 %	$ 719	15.2 %
Operating income as a % of total revenues	4.4 %	3.8 %	3.3 %				
Adjusted operating income [1]	$ 6,859	$ 5,688	$ 5,129	$ 1,171	20.6 %	$ 559	10.9 %
Adjusted operating income as a % of total revenues	4.5 %	4.0 %	3.6 %				
Revenues (by distribution channel):							
Pharmacy network [2]	$ 91,715	$ 85,045	$ 88,755	$ 6,670	7.8 %	$ (3,710)	(4.2)%
Mail choice [3]	60,547	56,071	52,141	4,476	8.0 %	3,930	7.5 %
Other	760	822	595	(62)	(7.5)%	227	38.2 %
Pharmacy claims processed: [4]							
Total	2,244.7	2,112.9	2,014.2	131.8	6.2 %	98.7	4.9 %
Pharmacy network [2]	1,914.0	1,790.1	1,704.0	123.9	6.9 %	86.1	5.1 %
Mail choice [3]	330.7	322.8	310.2	7.9	2.4 %	12.6	4.1 %
Generic dispensing rate: [4]							
Total	86.8 %	88.2 %	88.2 %				
Pharmacy network [2]	87.0 %	88.7 %	88.7 %				
Mail choice [3]	85.6 %	85.3 %	85.1 %				

(1) See "Segment Analysis" above in this MD&A for a reconciliation of operating income (GAAP measure) to adjusted operating income for the Pharmacy Services segment, which represents the Company's principal measure of segment performance.

(2) Pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including the Company's retail pharmacies and LTC pharmacies, but excluding Maintenance Choice® activity, which is included within the mail choice category. Maintenance Choice permits eligible client plan members to fill their maintenance prescriptions through mail order delivery or at a CVS Pharmacy retail store for the same price as mail order.

(3) Mail choice is defined as claims filled at a Pharmacy Services mail order facility, which includes specialty mail claims inclusive of Specialty Connect® claims picked up at a retail pharmacy, as well as prescriptions filled at the Company's retail pharmacies under the Maintenance Choice program.

(4) Includes an adjustment to convert 90-day prescriptions to the equivalent of three 30-day prescriptions. This adjustment reflects the fact that these prescriptions include approximately three times the amount of product days supplied compared to a normal prescription.

Commentary - 2021 compared to 2020

Revenues

- Total revenues increased $11.1 billion, or 7.8%, to $153.0 billion in 2021 compared to 2020. The increase was primarily driven by increased pharmacy claims volume, growth in specialty pharmacy and brand inflation, partially offset by continued price compression.

Operating expenses

- Operating expenses in the Pharmacy Services segment include selling, general and administrative expenses; depreciation and amortization expense; and expenses related to specialty retail pharmacies, which include store and administrative payroll, employee benefits and occupancy costs.
- Operating expenses as a percentage of total revenues remained consistent at 1.0% in both 2021 and 2020.

Adjusted operating income

- Adjusted operating income increased $1.2 billion, or 20.6%, in 2021 compared to 2020. The increase in adjusted operating income was primarily driven by improved purchasing economics which reflected increased contributions from the products and services of the Company's group purchasing organization and specialty pharmacy (including pharmacy and/or administrative services for providers and Covered Entities). These increases were partially offset by continued price compression.
- As you review the Pharmacy Services segment's performance in this area, you should consider the following important information about the business:
    - The Company's efforts to (i) retain existing clients, (ii) obtain new business and (iii) maintain or improve the rebates, fees and/or discounts the Company receives from manufacturers, wholesalers and retail pharmacies continue to have an impact on adjusted operating income. In particular, competitive pressures in the PBM industry have caused the Company and other PBMs to continue to share with clients a larger portion of rebates, fees and/or discounts received from pharmaceutical manufacturers. In addition, marketplace dynamics and regulatory changes have limited the Company's ability to offer plan sponsors pricing that includes retail network "differential" or "spread," and the Company expects these trends to continue. The "differential" or "spread" is any difference between the drug price charged to plan sponsors, including Medicare Part D plan sponsors, by a PBM and the price paid for the drug by the PBM to the dispensing provider.

Pharmacy claims processed

- Total pharmacy claims processed represents the number of prescription claims processed through our pharmacy benefits manager and dispensed by either our retail network pharmacies or our own mail and specialty pharmacies. Management uses this metric to understand variances between actual claims processed and expected amounts as well as trends in period-over-period results. This metric provides management and investors with information useful in understanding the impact of pharmacy claim volume on segment total revenues and operating results.
- The Company's pharmacy network claims processed on a 30-day equivalent basis increased 6.9% to 1.9 billion claims in 2021 compared to 1.8 billion claims in 2020. The increase in pharmacy network claims processed was primarily driven by net new business and COVID-19 vaccinations, as well as increased new therapy prescriptions, which were adversely impacted by the COVID-19 pandemic during 2020.
- The Company's mail choice claims processed on a 30-day equivalent basis increased 2.4% to 330.7 million claims in 2021 compared to 322.8 million claims in 2020. The increase in mail choice claims was primarily driven by net new business and the continued adoption of Maintenance Choice offerings.
- Excluding the impact of COVID-19 vaccinations, total pharmacy claims processed increased 4.2%, on a 30-day equivalent basis, in 2021 compared to the prior year.

Generic dispensing rate

- Generic dispensing rate is calculated by dividing the Pharmacy Services segment's generic drug prescriptions processed or filled by its total prescriptions processed or filled. Management uses this metric to evaluate the effectiveness of the business at encouraging the use of generic drugs when they are available and clinically appropriate, which aids in decreasing costs for client members and retail customers. This metric provides management and investors with information useful in understanding trends in segment total revenues and operating results.
- The Pharmacy Services segment's total generic dispensing rate decreased to 86.8% in 2021 compared to 88.2% in the prior year. The decrease in the segment's generic dispensing rate was primarily driven by an increase in brand prescriptions, largely attributable to COVID-19 vaccinations in 2021. Excluding the impact of COVID-19 vaccinations, the segment's total generic dispensing rate increased to 88.5% in 2021.

Retail/LTC Segment

The following table summarizes the Retail/LTC segment's performance for the respective periods:

	Year Ended December 31,			Change			
				2021 vs. 2020		2020 vs. 2019	
In millions, except percentages	**2021**	**2020**	**2019**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ 95,652	$ 89,944	$ 85,729	$ 5,708	6.3 %	$ 4,215	4.9 %
Services	4,436	1,254	879	3,182	253.7 %	375	42.7 %
Net investment income	17	—	—	17	100.0 %	—	— %
Total revenues	100,105	91,198	86,608	8,907	9.8 %	4,590	5.3 %
Cost of products sold	72,832	67,284	62,688	5,548	8.2 %	4,596	7.3 %
Store impairments	1,358	—	231	1,358	100.0 %	(231)	(100.0)%
Goodwill impairment	431	—	—	431	100.0 %	—	— %
Operating expenses	20,162	18,274	17,896	1,888	10.3 %	378	2.1 %
Operating expenses as a % of total revenues	20.1 %	20.0 %	20.7 %				
Operating income	$ 5,322	$ 5,640	$ 5,793	$ (318)	(5.6)%	$ (153)	(2.6)%
Operating income as a % of total revenues	5.3 %	6.2 %	6.7 %				
Adjusted operating income [1]	$ 7,623	$ 6,146	$ 6,705	$ 1,477	24.0 %	$ (559)	(8.3)%
Adjusted operating income as a % of total revenues	7.6 %	6.7 %	7.7 %				
Revenues (by major goods/ service lines):							
Pharmacy	$ 76,121	$ 70,176	$ 66,442	$ 5,945	8.5 %	$ 3,734	5.6 %
Front Store	21,315	19,655	19,422	1,660	8.4 %	233	1.2 %
Other	2,652	1,367	744	1,285	94.0 %	623	83.7 %
Net investment income	17	—	—	17	100.0 %	—	— %
Prescriptions filled [2]	1,587.6	1,465.2	1,417.2	122.4	8.4 %	48.0	3.4 %
Same store sales increase: [3]							
Total	8.9 %	5.6 %	3.7 %				
Pharmacy	9.3 %	7.0 %	4.5 %				
Front Store	7.6 %	0.9 %	1.1 %				
Prescription volume [2]	9.3 %	4.7 %	7.2 %				
Generic dispensing rate [2]	85.7 %	88.3 %	88.3 %				

(1) See "Segment Analysis" above in this MD&A for a reconciliation of operating income (GAAP measure) to adjusted operating income for the Retail/LTC segment, which represents the Company's principal measure of segment performance.

(2) Includes an adjustment to convert 90-day prescriptions to the equivalent of three 30-day prescriptions. This adjustment reflects the fact that these prescriptions include approximately three times the amount of product days supplied compared to a normal prescription.

(3) Same store sales and prescription volume represent the change in revenues and prescriptions filled in the Company's retail pharmacy stores that have been operating for greater than one year, expressed as a percentage that indicates the increase or decrease relative to the comparable prior period. Same store metrics exclude revenues from MinuteClinic, revenues and prescriptions from LTC operations and, in 2019, revenues and prescriptions from stores in Brazil. Management uses these metrics to evaluate the performance of existing stores on a comparable basis and to inform future decisions regarding existing stores and new locations. Same-store metrics provide management and investors with information useful in understanding the portion of current revenues and prescriptions resulting from organic growth in existing locations versus the portion resulting from opening new stores.

Commentary - 2021 compared to 2020

Revenues

- Total revenues increased $8.9 billion, or 9.8%, to $100.1 billion in 2021 compared to 2020. The increase was primarily driven by increased prescription and front store volume, the administration of COVID-19 vaccinations and diagnostic testing, as well as brand inflation. These increases were partially offset by continued pharmacy reimbursement pressure and the impact of recent generic introductions. COVID-19 vaccinations, diagnostic testing and OTC test kit sales contributed approximately 45% of the increase in the segment's revenues in 2021 compared to the prior year. The prior year reflected

the ongoing expansion of the Company's diagnostic testing program which began in April 2020, an immaterial impact from COVID-19 vaccinations which began in December 2020 and no OTC test kit sales.

- Pharmacy same store sales increased 9.3% in 2021 compared to 2020. The increase was driven by the 9.3% increase in pharmacy same store prescription volume on a 30-day equivalent basis and brand inflation. These increases were partially offset by continued pharmacy reimbursement pressure and the impact of recent generic introductions.
- Front store same store sales increased 7.6% in 2021 compared to 2020. The increase was primarily due to strength in consumer health, including the sale of OTC test kits, as well as increased beauty and personal care sales in 2021.
- Other revenues increased 94.0% in 2021 compared to 2020. The increase was primarily due to increased COVID-19 diagnostic testing in 2021.

Store impairments

- During 2021, the Company recorded a store impairment charge of approximately $1.4 billion related to the write-down of operating lease right-of-use assets and property and equipment in connection with the planned closure of approximately 900 retail stores between 2022 and 2024. See Note 6 "Leases" included in Item 8 of this 10-K for additional information.

Goodwill impairment

- During 2021, the Company recorded a $431 million goodwill impairment charge related to the LTC reporting unit within the Retail/LTC segment. See Note 5 "Goodwill and Other Intangibles" included in Item 8 of this 10-K for additional information.

Operating expenses

- Operating expenses in the Retail/LTC segment include store payroll, store employee benefits, store occupancy costs, selling expenses, advertising expenses, depreciation and amortization expense and certain administrative expenses.
- Operating expenses increased $1.9 billion, or 10.3%, in 2021 compared to 2020. The increase was primarily due to incremental costs associated with increased volume including COVID-19 vaccinations and diagnostic testing, as well as increased investments in the segment's capabilities and colleague compensation and benefits. These increases were partially offset by gains from anti-trust legal settlements of $231 million recorded in 2021, the absence of incremental expenses associated with the Company's initial COVID-19 pandemic mitigation efforts incurred in 2020 and the impact of cost savings initiatives in 2021.
- Operating expenses as a percentage of total revenues remained relatively consistent at 20.1% and 20.0% in 2021 and 2020, respectively.

Adjusted operating income

- Adjusted operating income increased $1.5 billion, or 24.0%, in 2021 compared to 2020. The increase in adjusted operating income was primarily driven by the administration of COVID-19 vaccinations and diagnostic testing, the increased prescription and front store volume described above, improved generic drug purchasing and gains from anti-trust legal settlements of $231 million recorded in 2021. These increases were partially offset by continued pharmacy reimbursement pressure and increased investments in the segment's capabilities and colleague compensation and benefits.
- As you review the Retail/LTC segment's performance in this area, you should consider the following important information about the business:
    - The segment's adjusted operating income benefited from the administration of COVID-19 vaccinations, diagnostic testing and OTC test kit sales which contributed approximately 30% of the segment's adjusted operating income in 2021.
    - The segment's adjusted operating income has been adversely affected by the efforts of managed care organizations, PBMs and governmental and other third-party payors to reduce their prescription drug costs, including the use of restrictive networks, as well as changes in the mix of business within the pharmacy portion of the Retail/LTC segment. If the pharmacy reimbursement pressure accelerates, the segment may not be able to grow revenues, and its adjusted operating income could be adversely affected.
    - The increased use of generic drugs has positively impacted the segment's adjusted operating income but has resulted in third-party payors augmenting their efforts to reduce reimbursement payments to retail

pharmacies for prescriptions. This trend, which the Company expects to continue, reduces the benefit the segment realizes from brand-to-generic drug conversions.

Prescriptions filled

- Prescriptions filled represents the number of prescriptions dispensed through the Retail/LTC segment's pharmacies. Management uses this metric to understand variances between actual prescriptions dispensed and expected amounts as well

as trends in period-over-period results. This metric provides management and investors with information useful in understanding the impact of prescription volume on segment total revenues and operating results.

- Prescriptions filled increased 8.4%, on a 30-day equivalent basis, in 2021 compared to 2020 primarily driven by COVID-19 vaccinations and the continued adoption of patient care programs, as well as increased new therapy prescriptions, which were adversely impacted by the COVID-19 pandemic in 2020. Excluding the impact of COVID-19 vaccinations, prescriptions filled increased 4.3%, on a 30-day equivalent basis, in 2021 compared to the prior year.

Generic dispensing rate

- Generic dispensing rate is calculated by dividing the Retail/LTC segment's generic drug prescriptions filled by its total prescriptions filled. Management uses this metric to evaluate the effectiveness of the business at encouraging the use of generic drugs when they are available and clinically appropriate, which aids in decreasing costs for client members and retail customers. This metric provides management and investors with information useful in understanding trends in segment total revenues and operating results.
- The Retail/LTC segment's generic dispensing rate decreased to 85.7% in 2021 compared to 88.3% in the prior year. The decrease in the segment's generic dispensing rate was primarily driven by an increase in brand prescriptions, largely attributable to COVID-19 vaccinations in 2021. Excluding the impact of COVID-19 vaccinations, the segment's total generic dispensing rate increased to 89.0% in 2021.

Corporate/Other Segment

The following table summarizes the Corporate/Other segment's performance for the respective periods:

				Change			
	Year Ended December 31,			2021 vs. 2020		2020 vs. 2019	
In millions, except percentages	**2021**	**2020**	**2019**	**$**	**%**	**$**	**%**
Revenues:							
Premiums	$ 68	$ 63	$ 91	$ 5	7.9 %	$ (28)	(30.8)%
Services	57	48	9	9	18.8 %	39	433.3 %
Net investment income	596	315	412	281	89.2 %	(97)	(23.5)%
Total revenues	721	426	512	295	69.2 %	(86)	(16.8)%
Cost of products sold	37	—	—	37	100.0 %	—	— %
Benefit costs	212	221	285	(9)	(4.1)%	(64)	(22.5)%
Operating expenses	2,078	1,846	1,710	232	12.6 %	136	8.0 %
Operating loss	(1,606)	(1,641)	(1,483)	35	2.1 %	(158)	(10.7)%
Adjusted operating loss [1]	(1,471)	(1,306)	(1,000)	(165)	(12.6)%	(306)	(30.6)%

(1) See "Segment Analysis" above in this MD&A for a reconciliation of Corporate/Other segment operating loss (GAAP measure) to adjusted operating loss, which represents the Company's principal measure of segment performance.

Commentary - 2021 compared to 2020

Revenues

- Revenues primarily relate to products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products.
- Total revenues increased $295 million in 2021 compared to 2020. The increase was primarily driven by higher net investment income, primarily driven by private equity investments and increased net realized capital gains in 2021 compared to 2020.

Adjusted operating loss

- Adjusted operating loss increased $165 million in 2021 compared to 2020. The increase was primarily driven by higher employee benefit costs and incremental operating expenses associated with the Company's investments in transformation, partially offset by the increase in net investment income in 2021 described above.

Liquidity and Capital Resources

Cash Flows

The Company maintains a level of liquidity sufficient to allow it to meet its cash needs in the short-term. Over the long term, the Company manages its cash and capital structure to maximize shareholder return, maintain its financial condition and maintain flexibility for future strategic initiatives. The Company continuously assesses its regulatory capital requirements, working capital needs, debt and leverage levels, debt maturity schedule, capital expenditure requirements, dividend payouts, potential share repurchases and future investments or acquisitions. The Company believes its operating cash flows, commercial paper program, credit facilities, as well as any potential future borrowings, will be sufficient to fund these future payments and long-term initiatives. As of December 31, 2021, the Company had approximately $9.4 billion in cash and cash equivalents, approximately $3.8 billion of which was held by the parent company or nonrestricted subsidiaries.

The net change in cash, cash equivalents and restricted cash for the years ended December 31, 2021, 2020 and 2019 was as follows:

				Change			
	Year Ended December 31,			2021 vs. 2020		2020 vs. 2019	
In millions	2021	2020	2019	$	%	$	%
Net cash provided by operating activities	$ 18,265	$ 15,865	$ 12,848	$ 2,400	15.1 %	$ 3,017	23.5 %
Net cash used in investing activities	(5,261)	(5,534)	(3,339)	273	4.9 %	(2,195)	(65.7)%
Net cash used in financing activities	(11,356)	(7,696)	(7,654)	(3,660)	(47.6)%	(42)	(0.5)%
Net increase in cash, cash equivalents and restricted cash	$ 1,648	$ 2,635	$ 1,855	$ (987)	(37.5)%	$ 780	42.0 %

Commentary - 2021 compared to 2020

- *Net cash provided by operating activities* increased by $2.4 billion in 2021 compared to 2020 due primarily to the timing of payments and higher operating income in the Retail/LTC segment. The increase was partially offset by reduced benefit costs due to the deferral of elective procedures and other discretionary utilization in the Health Care Benefits segment as a result of the COVID-19 pandemic, which favorably impacted operating cash flows in 2020 and did not recur during the current year.
- *Net cash used in investing activities* decreased by $273 million in 2021 compared to 2020 primarily due to increased proceeds from the sale and maturity of investments and a decrease in cash used for acquisitions, partially offset by the absence of $840 million in proceeds from the sale of the Workers' Compensation business in 2020 and increased purchases of investments during 2021 compared to the prior year. In addition, cash used in investing activities reflected the following activity:
    - Gross capital expenditures remained relatively consistent at approximately $2.5 billion and $2.4 billion in 2021 and 2020, respectively. During 2021, approximately 64% of the Company's total capital expenditures were for technology, digital and other strategic initiatives and 36% were for store, fulfillment and support facilities expansion and improvements.
- *Net cash used in financing activities* increased to $11.4 billion in 2021 compared to $7.7 billion in 2020. The increase in cash used in finance activities primarily related to lower proceeds from the issuance of long-term debt, partially offset by lower repayments of long-term debt during 2021 compared to the prior year.

Included in net cash used in investing activities for the years ended December 31, 2021, 2020 and 2019 was the following store development activity: [(1)]

	2021	2020	2019
Total stores (beginning of year)	9,962	9,896	9,921
New and acquired stores [2]	58	156	102
Closed stores [2]	(81)	(90)	(127)
Total stores (end of year)	9,939	9,962	9,896
Relocated stores [2]	17	18	23

(1) Includes retail drugstores and pharmacies within retail chains, primarily in Target Corporation ("Target") stores.

(2) Relocated stores are not included in new and acquired stores or closed stores totals.

Short-term Borrowings

Commercial Paper and Back-up Credit Facilities
The Company did not have any commercial paper outstanding as of December 31, 2021 or 2020. In connection with its commercial paper program, the Company maintains a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 17, 2023, a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 16, 2024, and a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 11, 2026. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately 0.03%, regardless of usage. As of December 31, 2021 and 2020, there were no borrowings outstanding under any of the Company's back-up credit facilities.

Federal Home Loan Bank of Boston ("FHLBB")
A subsidiary of the Company is a member of the FHLBB. As a member, the subsidiary has the ability to obtain cash advances, subject to certain minimum collateral requirements. The maximum borrowing capacity available from the FHLBB as of December 31, 2021 was approximately $995 million. At both December 31, 2021 and 2020, there were no outstanding advances from the FHLBB.

Long-term Borrowings

2021 Notes
On August 18, 2021, the Company issued $1.0 billion aggregate principal amount of 2.125% unsecured senior notes due September 15, 2031 for total proceeds of $987 million, net of discounts, underwriting fees and offering expenses. The net proceeds of this offering were used for the purchase of senior notes in connection with the Company's cash tender offer in August 2021 as described below.

2020 Notes
On December 16, 2020, the Company issued $750 million aggregate principal amount of 1.3% unsecured senior notes due August 21, 2027 and $1.25 billion aggregate principal amount of 1.875% unsecured senior notes due February 28, 2031 for total proceeds of approximately $1.99 billion, net of discounts and underwriting fees. The $750 million aggregate principal amount of 1.3% unsecured senior notes represent a further issuance of the Company's 1.3% unsecured senior notes due August 21, 2027 initially issued in an aggregate principal amount of $1.5 billion on August 21, 2020.

On August 21, 2020, the Company issued $1.5 billion aggregate principal amount of 1.3% unsecured senior notes due August 21, 2027, $1.25 billion aggregate principal amount of 1.75% unsecured senior notes due August 21, 2030 and $1.25 billion aggregate principal amount of 2.7% unsecured senior notes due August 21, 2040 (collectively, the "August 2020 Notes") for total proceeds of approximately $3.97 billion, net of discounts and underwriting fees.

On March 31, 2020, the Company issued $750 million aggregate principal amount of 3.625% unsecured senior notes due April 1, 2027, $1.5 billion aggregate principal amount of 3.75% unsecured senior notes due April 1, 2030, $1.0 billion aggregate principal amount of 4.125% unsecured senior notes due April 1, 2040 and $750 million aggregate principal amount of 4.25% unsecured senior notes due April 1, 2050 (collectively, the "March 2020 Notes") for total proceeds of approximately $3.95 billion, net of discounts and underwriting fees.

The net proceeds of these offerings were used for general corporate purposes, which may include working capital, capital expenditures, as well as the repurchase and/or repayment of indebtedness.

During March 2020, the Company entered into several interest rate swap transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of the March 2020 Notes. In connection with the issuance of the March 2020 Notes, the Company terminated all outstanding cash flow hedges. The Company paid a net amount of $7 million to the hedge counterparties upon termination, which was recorded as a loss, net of tax, of $5 million in accumulated other comprehensive income and will be reclassified as interest expense

over the life of the March 2020 Notes. See Note 13 ‘‘Other Comprehensive Income’’ included in Item 8 of this 10-K for additional information.

Early Extinguishments of Debt
In December 2021, the Company redeemed for cash the remaining $2.3 billion of its outstanding 3.7% senior notes due 2023. In connection with the early redemption of such senior notes, the Company paid a make-whole premium of $80 million in excess of the aggregate principal amount of the senior notes that were redeemed, wrote-off $8 million of unamortized deferred financing costs and incurred $1 million in fees, for a total loss on early extinguishment of debt of $89 million.

In August 2021, the Company purchased approximately $2.0 billion of its outstanding 4.3% senior notes due 2028 through a cash tender offer. In connection with the purchase of such senior notes, the Company paid a premium of $332 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $26 million of unamortized deferred financing costs and incurred $5 million in fees, for a total loss on early extinguishment of debt of $363 million.

In December 2020, the Company purchased $4.5 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $113 million of its 4.0% senior notes due 2023, $1.4 billion of its 3.7% senior notes due 2023, $1.0 billion of its 4.1% senior notes due 2025 and $2.0 billion of its 4.3% senior notes due 2028. In connection with the purchase of such senior notes, the Company paid a premium of $619 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $45 million of unamortized deferred financing costs and incurred $10 million in fees, for a total loss on early extinguishment of debt of $674 million.

In August 2020, the Company purchased $6.0 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $723 million of its 4.0% senior notes due 2023, $2.3 billion of its 3.7% senior notes due 2023 and $3.0 billion of its 4.1% senior notes due 2025. In connection with the purchase of such senior notes, the Company paid a premium of $706 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $47 million of unamortized deferred financing costs and incurred $13 million in fees, for a total loss on early extinguishment of debt of $766 million.

In August 2019, the Company purchased $4.0 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $1.3 billion of its 3.125% senior notes due 2020, $723 million of its floating rate notes due 2020, $328 million of its 4.125% senior notes due 2021, $297 million of 4.125% senior notes due 2021 issued by Aetna, $413 million of 5.45% senior notes due 2021 issued by Coventry Health Care, Inc., a wholly-owned subsidiary of Aetna, and $962 million of its 3.35% senior notes due 2021. In connection with the purchase of such senior notes, the Company paid a premium of $76 million in excess of the aggregate principal amount of the senior notes that were purchased, incurred $8 million in fees and recognized a net gain of $5 million on the write-off of net unamortized deferred financing premiums, for a net loss on early extinguishment of debt of $79 million.

See Note 8 ‘‘Borrowings and Credit Agreements’’ and Note 12 ‘‘Shareholders’ Equity’’ included in Item 8 of this 10-K for additional information about debt issuances, debt repayments, share repurchases and dividend payments.

Derivative Financial Instruments

The Company uses derivative financial instruments in order to manage interest rate and foreign exchange risk and credit exposure. The Company’s use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps.

Debt Covenants

The Company’s back-up revolving credit facilities, unsecured senior notes and unsecured floating rate notes (see Note 8 ‘‘Borrowings and Credit Agreements’’ included in Item 8 of this 10-K) contain customary restrictive financial and operating covenants. These covenants do not include an acceleration of the Company’s debt maturities in the event of a downgrade in the Company’s credit ratings. The Company does not believe the restrictions contained in these covenants materially affect its financial or operating flexibility. As of December 31, 2021, the Company was in compliance with all of its debt covenants.

Debt Ratings

As of December 31, 2021, the Company's long-term debt was rated "Baa2" by Moody's Investors Service, Inc. ("Moody's") and "BBB" by Standard & Poor's Financial Services LLC ("S&P"), and its commercial paper program was rated "P-2" by Moody's and "A-2" by S&P. The outlook on the Company's long-term debt is "Stable" by Moody's and "Positive" by S&P. In assessing the Company's credit strength, the Company believes that both Moody's and S&P considered, among other things, the Company's capital structure and financial policies as well as its consolidated balance sheet, its historical acquisition activity

and other financial information. Although the Company currently believes its long-term debt ratings will remain investment grade, it cannot guarantee the future actions of Moody's and/or S&P. The Company's debt ratings have a direct impact on its future borrowing costs, access to capital markets and new store operating lease costs.

Share Repurchase Programs

During the years ended December 31, 2021, 2020 and 2019, the Company did not repurchase any shares of common stock. See Note 12 ''Shareholders' Equity'' included in Item 8 of this 10-K for additional information on the Company's share repurchase program.

Quarterly Cash Dividend

During 2021, 2020 and 2019, the quarterly cash dividend was $0.50 per share. In December 2021, CVS Health Corporation's Board of Directors (the "Board") authorized a 10% increase in the quarterly cash dividend to $0.55 per share effective in 2022. CVS Health Corporation has paid cash dividends every quarter since becoming a public company. Future dividends will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

Future Cash Requirements

The following table summarizes certain estimated future cash requirements under the Company's various contractual obligations at December 31, 2021, in total and disaggregated into current and long-term obligations. The table below does not include future payments of claims to health care providers or pharmacies because certain terms of these payments are not determinable at December 31, 2021 (for example, the timing and volume of future services provided under fee-for-service arrangements and future membership levels for capitated arrangements).

In millions	**Total**	**Current**	**Long-Term**
Operating lease liabilities [1]	$ 26,070	$ 2,685	$ 23,385
Finance lease liabilities [1]	2,068	122	1,946
Contractual lease obligations with Target [2]	2,419	—	2,419
Long-term debt [3]	55,443	4,154	51,289
Interest payments on long-term debt [3]	31,668	2,196	29,472
Other long-term liabilities on the consolidated balance sheets [4]			
Future policy benefits [5]	5,553	416	5,137
Unpaid claims [5]	1,589	324	1,265
Policyholders' funds [5] [6]	1,761	1,266	495
Total	$ 126,571	$ 11,163	$ 115,408

(1) Refer to Note 6 ''Leases'' included in Item 8 of this 10-K for additional information regarding the maturity of lease liabilities under operating and finance leases.

(2) The Company leases pharmacy and clinic space from Target. See Note 6 ''Leases'' included in Item 8 of this 10-K for additional information regarding the lease arrangements with Target. Amounts related to such operating and finance leases are reflected within the operating lease liabilities and finance lease liabilities in the table above. Pharmacy lease amounts due in excess of the remaining estimated economic life of the buildings are reflected in the table above assuming equivalent stores continue to operate through the term of the arrangements.

(3) Refer to Note 8 ''Borrowings and Credit Agreements'' included in Item 8 of this 10-K for additional information regarding the maturities of debt principal. Interest payments on long-term debt are calculated using outstanding balances and interest rates in effect on December 31, 2021.

(4) Payments of other long-term liabilities exclude Separate Accounts liabilities of approximately $5.1 billion because these liabilities are supported by assets that are legally segregated and are not subject to claims that arise out of the Company's business.

(5) Total payments of future policy benefits, unpaid claims and policyholders' funds include $728 million, $1.6 billion and $186 million, respectively, of reserves for contracts subject to reinsurance. The Company expects the assuming reinsurance carrier to fund these obligations and has reflected these amounts as reinsurance recoverable assets on the consolidated balance sheets.

(6) Customer funds associated with group life and health contracts of approximately $3.0 billion have been excluded from the table above because such funds may be used primarily at the customer's discretion to offset future premiums and/or for refunds, and the timing of the related cash flows cannot be determined. Additionally, net unrealized capital gains on debt securities supporting experience-rated products of $92 million, before tax, have been excluded from the table above.

Restrictions on Certain Payments

In addition to general state law restrictions on payments of dividends and other distributions to stockholders applicable to all corporations, health maintenance organizations ("HMOs") and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity (referred to as surplus) and restrict the

amount of dividends and other distributions that may be paid to their equity holders. These regulations are not directly applicable to CVS Health Corporation as a holding company, since CVS Health Corporation is not an HMO or an insurance company. In addition, in connection with the Aetna Acquisition, the Company made certain undertakings that require prior regulatory approval of dividends by certain of its HMOs and insurance companies. The additional regulations and undertakings applicable to the Company's HMO and insurance company subsidiaries are not expected to affect the Company's ability to service the Company's debt, meet other financing obligations or pay dividends, or the ability of any of the Company's subsidiaries to service their debt or other financing obligations. Under applicable regulatory requirements and undertakings, at December 31, 2021, the maximum amount of dividends that may be paid by the Company's insurance and HMO subsidiaries without prior approval by regulatory authorities was $2.9 billion in the aggregate.

The Company maintains capital levels in its operating subsidiaries at or above targeted and/or required capital levels and dividends amounts in excess of these levels to meet liquidity requirements, including the payment of interest on debt and stockholder dividends. In addition, at the Company's discretion, it uses these funds for other purposes such as funding share and debt repurchase programs, investments in new businesses and other purposes considered advisable.

At December 31, 2021 and 2020, the Company held investments of $450 million and $524 million, respectively, that are not accounted for as Separate Accounts assets but are legally segregated and are not subject to claims that arise out of the Company's business. See Note 3 ''Investments'' included in Item 8 of this 10-K for additional information on investments related to the 2012 conversion of an existing group annuity contract from a participating to a non-participating contract.

Solvency Regulation

The National Association of Insurance Commissioners (the "NAIC") utilizes risk-based capital ("RBC") standards for insurance companies that are designed to identify weakly-capitalized companies by comparing each company's adjusted surplus to its required surplus (the "RBC Ratio"). The RBC Ratio is designed to reflect the risk profile of insurance companies. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring an insurer to submit a comprehensive financial plan for increasing its RBC to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2021, the RBC Ratio of each of the Company's primary insurance subsidiaries was above the level that would require regulatory action. The RBC framework described above for insurers has been extended by the NAIC to health organizations, including HMOs. Although not all states had adopted these rules at December 31, 2021, at that date, each of the Company's active HMOs had a surplus that exceeded either the applicable state net worth requirements or, where adopted, the levels that would require regulatory action under the NAIC's RBC rules. External rating agencies use their own capital models and/or RBC standards when they determine a company's rating.

Critical Accounting Policies

The Company prepares the consolidated financial statements in conformity with generally accepted accounting principles, which require management to make certain estimates and apply judgment. Estimates and judgments are based on historical experience, current trends and other factors that management believes to be important at the time the consolidated financial statements are prepared. On a regular basis, the Company reviews its accounting policies and how they are applied and disclosed in the consolidated financial statements. While the Company believes the historical experience, current trends and other factors considered by management support the preparation of the consolidated financial statements in conformity with generally accepted accounting principles, actual results could differ from estimates, and such differences could be material.

Significant accounting policies are discussed in Note 1 ‘‘Significant Accounting Policies’’ included in Item 8 of this 10-K. Management believes the following accounting policies include a higher degree of judgment and/or complexity and, thus, are considered to be critical accounting policies. The Company has discussed the development and selection of these critical accounting policies with the Audit Committee of the Board (the “Audit Committee”), and the Audit Committee has reviewed the disclosures relating to them.

Revenue Recognition

Health Care Benefits Segment
Health Care Benefits revenue is principally derived from insurance premiums and fees billed to customers. Revenue is recognized based on customer billings, which, in the Company’s Commercial business, reflect contracted rates per member and the number of covered members recorded in the Company’s records at the time the billings are prepared. Billings are generally sent monthly for coverage during the following month. Revenue related to the Company’s Government business is collected monthly from the U.S. federal government and various government agencies based on fixed payment rates and member eligibility.

The Company’s billings may be subsequently adjusted to reflect enrollment changes due to member terminations or other factors. These adjustments are known as retroactivity adjustments. In each period, the Company estimates the amount of future retroactivity and adjusts the recorded revenue accordingly. As information regarding actual retroactivity amounts becomes known, the Company refines its estimates and records any required adjustments to revenues in the period in which they arise. A significant difference in the actual level of retroactivity compared to estimated levels would have a significant effect on the Company’s operating results.

Premium Revenue
Premiums are recognized as revenue in the month in which the enrollee is entitled to receive health care services. Premiums are reported net of an allowance for estimated terminations and uncollectible amounts. Additionally, premium revenue subject to the MLR rebate requirements of the ACA is recorded net of the estimated minimum MLR rebates for the current calendar year. Premiums related to unexpired contractual coverage periods (unearned premiums) are reported as other insurance liabilities on the consolidated balance sheets and recognized as revenue when earned.

Some of the Company’s contracts allow for premiums to be adjusted to reflect actual experience or the relative health status of Insured members. Such adjustments are reasonably estimable at the outset of the contract, and adjustments to those estimates are made based on actual experience of the customer emerging under the contract and the terms of the underlying contract.

Services Revenue
Services revenue relates to contracts that can include various combinations of services or series of services which generally are capable of being distinct and accounted for as separate performance obligations. The Health Care Benefits segment’s services revenue primarily consists of ASC fees received in exchange for performing certain claim processing and member services for ASC members. ASC fee revenue is recognized over the period the service is provided. Some of the Company’s administrative services contracts include guarantees with respect to certain functions, such as customer service response time, claim processing accuracy and claim processing turnaround time, as well as certain guarantees that a plan sponsor’s benefit claim experience will fall within a certain range. With any of these guarantees, the Company is financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk typically is limited to a percentage of the fees otherwise payable to the Company by the

customer involved. Each period the Company estimates its obligations under the terms of these guarantees and records its estimate as an offset to services revenues.

Accounting for Medicare Part D

Revenues include insurance premiums earned by the Company's PDPs, which are determined based on the PDP's annual bid and related contractual arrangements with CMS. The insurance premiums include a beneficiary premium, which is the responsibility of the PDP member, and can be subsidized by CMS in the case of low-income members, and a direct premium paid by CMS. Premiums collected in advance are initially recorded within other insurance liabilities and are then recognized ratably as revenue over the period in which members are entitled to receive benefits.

Revenues also include a risk-sharing feature of the Medicare Part D program design referred to as the risk corridor. The Company estimates variable consideration in the form of amounts payable to, or receivable from, CMS under the risk corridor, and adjusts revenue based on calculations of additional subsidies to be received from or owed to CMS at the end of the reporting year.

In addition to Medicare Part D premiums, the Company receives additional payments each month from CMS related to catastrophic reinsurance, low-income cost-sharing subsidies and coverage gap benefits. If the subsidies received differ from the amounts earned from actual prescriptions transferred, the difference is recorded in either accounts receivable, net or accrued expenses.

Pharmacy Services Segment

The Pharmacy Services segment sells prescription drugs directly through its mail service dispensing pharmacies and indirectly through the Company's retail pharmacy network. The Company's pharmacy benefit arrangements are accounted for in a manner consistent with a master supply arrangement as there are no contractual minimum volumes and each prescription is considered a separate purchasing decision and distinct performance obligation transferred at a point in time. PBM services performed in connection with each prescription claim are considered part of a single performance obligation which culminates in the dispensing of prescription drugs.

The Company recognizes revenue using the gross method at the contract price negotiated with its clients when the Company has concluded it controls the prescription drug before it is transferred to the client plan members. The Company controls prescriptions dispensed indirectly through its retail pharmacy network because it has separate contractual arrangements with those pharmacies, has discretion in setting the price for the transaction and assumes primary responsibility for fulfilling the promise to provide prescription drugs to its client plan members while also performing the related PBM services.

Revenues include (i) the portion of the price the client pays directly to the Company, net of any discounts earned on brand name drugs or other discounts and refunds paid back to the client (see "Drug Discounts" and "Guarantees" below), (ii) the price paid to the Company by client plan members for mail order prescriptions and the price paid to retail network pharmacies by client plan members for retail prescriptions ("retail co-payments"), and (iii) claims based administrative fees for retail pharmacy network contracts. Sales taxes are not included in revenues.

The Company recognizes revenue when control of the prescription drugs is transferred to customers, in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those prescription drugs. The Company has established the following revenue recognition policies for the Pharmacy Services segment:

- Revenues generated from prescription drugs sold by mail service dispensing pharmacies are recognized when the prescription drug is delivered to the client plan member. At the time of delivery, the Company has performed substantially all of its performance obligations under its client contracts and does not experience a significant level of returns or reshipments.
- Revenues generated from prescription drugs sold by third party pharmacies in the Company's retail pharmacy network and associated administrative fees are recognized at the Company's point-of-sale, which is when the claim is adjudicated by the Company's online claims processing system and the Company has transferred control of the prescription drug and completed all of its performance obligations.

For contracts under which the Company acts as an agent or does not control the prescription drugs prior to transfer to the client plan member, revenue is recognized using the net method.

Drug Discounts

The Company records revenue net of manufacturers' rebates earned by its clients based on their plan members' utilization of brand-name formulary drugs. The Company estimates these rebates at period-end based on actual and estimated claims data and its estimates of the manufacturers' rebates earned by its clients. The estimates are based on the best available data at period-end and recent history for the various factors that can affect the amount of rebates due to the client. The Company adjusts its rebates

payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. Any cumulative effect of these adjustments is recorded against revenues at the time it is identified. Adjustments generally result from contract changes with clients or manufacturers that have retroactive rebate adjustments, differences between the estimated and actual product mix subject to rebates, or whether the brand name drug was included in the applicable formulary. The effect of adjustments between estimated and actual manufacturers' rebate amounts has not been material to the Company's operating results or financial condition.

Guarantees

The Company also adjusts revenues for refunds owed to clients resulting from pricing guarantees and performance against defined service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Retail/LTC Segment

Retail Pharmacy

The Company's retail drugstores recognize revenue at the time the customer takes possession of the merchandise. For pharmacy sales, each prescription claim is its own arrangement with the customer and is a performance obligation, separate and distinct from other prescription claims under other retail network arrangements. Revenues are adjusted for refunds owed to third party payers resulting from pricing guarantees and performance against defined value-based service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Revenue from Company gift cards purchased by customers is deferred as a contract liability until goods or services are transferred. Any amounts not expected to be redeemed by customers (i.e., breakage) are recognized based on historical redemption patterns.

Customer returns are not material to the Company's operating results or financial condition. Sales taxes are not included in revenues.

Loyalty and Other Programs

The Company's customer loyalty program, ExtraCare®, consists of two components, ExtraSavings™ and ExtraBucks® Rewards. ExtraSavings are coupons that are recorded as a reduction of revenue when redeemed as the Company concluded that they do not represent a promise to the customer to deliver additional goods or services at the time of issuance because they are not tied to a specific transaction or spending level.

ExtraBucks Rewards are accumulated by customers based on their historical spending levels. Thus, the Company has determined that there is an additional performance obligation to those customers at the time of the initial transaction. The Company allocates the transaction price to the initial transaction and the ExtraBucks Rewards transaction based upon the relative standalone selling price, which considers historical redemption patterns for the rewards. Revenue allocated to ExtraBucks Rewards is recognized as those rewards are redeemed. At the end of each period, unredeemed ExtraBucks Rewards are reflected as a contract liability.

The Company also offers a subscription-based membership program, CarePass®, under which members are entitled to a suite of benefits delivered over the course of the subscription period, as well as a promotional reward that can be redeemed for future goods and services. Subscriptions are paid for on a monthly or annual basis at the time of or in advance of the Company delivering the goods and services. Revenue from these arrangements is recognized as the performance obligations are satisfied.

Long-term Care

Revenue is recognized when control of the promised goods or services is transferred to customers in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those goods or services. Each prescription claim represents a separate performance obligation of the Company, separate and distinct from other prescription claims under customer arrangements. A significant portion of long-term care revenue from sales of pharmaceutical and medical products is reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. The Company monitors its revenues and receivables from these reimbursement sources, as well as long-term care facilities and other third party insurance payors, and reduces revenue at the revenue

recognition date to properly account for the variable consideration due to anticipated differences between billed and reimbursed amounts. Accordingly, the total revenues and receivables reported in the Company's consolidated financial statements are recorded at the amount expected to be ultimately received from these payors.

Patient co-payments associated with Medicare Part D, certain state Medicaid programs, Medicare Part B and certain third party payors typically are not collected at the time products are delivered or services are rendered, but are billed to the individuals as part of normal billing procedures and subject to normal accounts receivable collections procedures.

Walk-In Medical Clinics
For services provided by the Company's walk-in medical clinics, revenue recognition occurs for completed services provided to patients, with adjustments taken for third party payor contractual obligations and patient direct bill historical collection rates.

Impairments of Debt Securities

The Company regularly reviews its debt securities to determine whether a decline in fair value below the cost basis or carrying value has occurred. If a debt security is in an unrealized loss position and the Company has the intent to sell the security, or it is more likely than not that the Company will have to sell the security before recovery of its amortized cost basis, the amortized cost basis of the security is written down to its fair value and the difference is recognized in net income. If a debt security is in an unrealized loss position and the Company does not have the intent to sell and it is more likely than not that the Company will not have to sell such security before recovery of its amortized cost basis, the Company bifurcates the impairment into credit-related and non-credit related components. The amount of the credit-related component is recorded as an allowance for credit losses and recognized in net income, and the amount of the non-credit related component is included in other comprehensive income. The Company analyzes all facts and circumstances believed to be relevant for each investment when performing this analysis, in accordance with applicable accounting guidance.

In evaluating whether a credit related loss exists, the Company considers a variety of factors including: the extent to which the fair value is less than the amortized cost basis; adverse conditions specifically related to the issuer of a security, an industry or geographic area; the payment structure of the security; the failure of the issuer of the security to make scheduled interest or principle payments; and any changes to the rating of the security by a rating agency.

During the years ended December 31, 2021 and 2020, the Company recorded yield-related impairment losses on debt securities of $42 million and $49 million, respectively. During the years ended December 31, 2021 and 2020, the Company did not record credit-related impairment losses on debt securities. During the year ended December 31, 2019, the Company recorded other-than-temporary impairment ("OTTI") losses on debt securities of $24 million.

The risks inherent in assessing the impairment of a debt security include the risk that market factors may differ from projections and the risk that facts and circumstances factored into the Company's assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods are among the factors that may result in a current period decision to sell debt securities that were not impaired in prior reporting periods.

Vendor Allowances and Purchase Discounts

Vendor and manufacturer receivables were $10.6 billion and $9.8 billion as of December 31, 2021 and 2020, respectively, the majority of which relate to purchase discounts and vendor allowances as described below.

Pharmacy Services Segment
The Pharmacy Services segment receives purchase discounts on products purchased. Contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for the Pharmacy Services segment to receive purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These rebates are recognized when prescriptions are dispensed and are generally calculated and billed to manufacturers within 30 days of the end of each completed quarter. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material to the Company's operating results or financial condition. The Company accounts for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. The Pharmacy Services

segment also receives additional discounts under its wholesaler contracts if it exceeds contractually defined purchase volumes. In addition, the Pharmacy Services segment receives fees from pharmaceutical manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of cost of products sold.

Retail/LTC Segment
Vendor allowances received by the Retail/LTC segment reduce the carrying cost of inventory and are recognized in cost of products sold when the related inventory is sold, unless they are specifically identified as a reimbursement of incremental costs for promotional programs and/or other services provided. Amounts that are directly linked to advertising commitments are recognized as a reduction of advertising expense (included in operating expenses) when the related advertising commitment is satisfied. Any such allowances received in excess of the actual cost incurred also reduce the carrying cost of inventory. The total value of any upfront payments received from vendors that are linked to purchase commitments is initially deferred. The deferred amounts are then amortized to reduce cost of products sold over the life of the contract based upon sales volume. The total value of any upfront payments received from vendors that are not linked to purchase commitments is also initially deferred. The deferred amounts are then amortized to reduce cost of products sold on a straight-line basis over the life of the related contract.

The Company establishes a receivable for vendor income that is earned but not yet received based on historical trends and data. The majority of vendor receivables are collected within the following fiscal quarter. Historically, adjustments to the Company's vendor receivables resulting from the reconciliation of receivables recognized to the amounts collected have not been material to the Company's operating results or financial condition.

There have not been any material changes in the way the Company accounts for vendor allowances or purchase discounts during the past three years.

Inventory

Inventories are valued at the lower of cost or net realizable value using the weighted average cost method.

The value of ending inventory is reduced for estimated inventory losses that have occurred during the interim period between physical inventory counts. Physical inventory counts are taken on a regular basis in each retail store and LTC pharmacy, and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the consolidated financial statements are properly stated. The Company's accounting for inventory contains uncertainty since management must use judgment to estimate the inventory losses that have occurred during the interim period between physical inventory counts. When estimating these losses, a number of factors are considered which include historical physical inventory results on a location-by-location basis and current physical inventory loss trends.

The total reserve for estimated inventory losses covered by this critical accounting policy was $522 million and $369 million as of December 31, 2021 and 2020, respectively. Although management believes there is sufficient current and historical information available to record reasonable estimates for estimated inventory losses, it is possible that actual results could differ. In order to help investors assess the aggregate risk, if any, associated with the inventory-related uncertainties discussed above, a ten percent (10%) pre-tax change in estimated inventory losses, which is a reasonably likely change, would increase or decrease the total reserve for estimated inventory losses by approximately $52 million as of December 31, 2021.

Although management believes that the estimates discussed above are reasonable and the related calculations conform to generally accepted accounting principles, actual results could differ from such estimates, and such differences could be material.

Right-of-Use Assets and Lease Liabilities

The Company determines if an arrangement contains a lease at the inception of a contract. Right-of-use assets represent the Company's right to use an underlying asset for the lease term and lease liabilities represent the Company's obligation to make lease payments arising from the lease. Right-of-use assets and lease liabilities are recognized at the commencement date of the lease, renewal date of the lease or significant remodeling of the lease space based on the present value of the remaining future minimum lease payments. As the interest rate implicit in the Company's leases is not readily determinable, the Company utilizes its incremental borrowing rate, determined by class of underlying asset, to discount the lease payments. The operating lease right-of-use assets also include lease payments made before commencement and are reduced by lease incentives. The Company evaluates the recoverability of its right-of-use assets as described in "Long-Lived Asset Impairment" below.

The Company's real estate leases typically contain options that permit renewals for additional periods of up to five years each. For real estate leases, the options to extend are not considered reasonably certain at lease commencement because the Company reevaluates each lease on a regular basis to consider the economic and strategic incentives of exercising the renewal options and

regularly opens or closes stores to align with its operating strategy. Generally, the renewal option periods are not included within the lease term and the associated payments are not included in the measurement of the right-of-use asset and lease liability. Similarly, renewal options are not included in the lease term for non-real estate leases because they are not considered reasonably certain of being exercised at lease commencement. Leases with an initial term of 12 months or less are not recorded on the balance sheets, and lease expense is recognized on a straight-line basis over the term of the short-term lease.

For real estate leases, the Company accounts for lease components and nonlease components as a single lease component. Certain real estate leases require additional payments based on sales volume, as well as reimbursement for real estate taxes, common area maintenance and insurance, which are expensed as incurred as variable lease costs. Other real estate leases contain one fixed lease payment that includes real estate taxes, common area maintenance and insurance. These fixed payments are considered part of the lease payment and included in the right-of-use assets and lease liabilities.

Long-Lived Asset Impairment

Recoverability of Definite-Lived Assets
The Company evaluates the recoverability of long-lived assets, excluding goodwill and indefinite-lived intangible assets, which are tested for impairment using separate tests described below, whenever events or changes in circumstances indicate that the carrying value of such an asset may not be recoverable. The Company groups and evaluates these long-lived assets for impairment at the lowest level at which individual cash flows can be identified. If indicators of impairment are present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted). If the estimated future cash flows used in this analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group's estimated future cash flows (discounted). If required, an impairment loss is recorded for the portion of the asset group's carrying value that exceeds the asset group's estimated future cash flows (discounted).

The long-lived asset impairment loss calculation contains uncertainty since management must use judgment to estimate each asset group's future sales, profitability and cash flows. When preparing these estimates, the Company considers historical results and current operating trends and consolidated sales, profitability and cash flow results and forecasts. These estimates can be affected by a number of factors including general economic and regulatory conditions, efforts of third party organizations to reduce their prescription drug costs and/or increased member co-payments, the continued efforts of competitors to gain market share and consumer spending patterns.

During the fourth quarter of 2021, the Company completed a strategic review of its retail business and announced the creation of new formats for its stores to continue to drive higher engagement with customers. As part of this review, the Company evaluated changes in population, consumer buying patterns and future health needs to ensure it has the right kinds of stores in the right locations for consumers and for the business. In connection with this initiative, on November 17, 2021, the Board of Directors of CVS Health Corporation (the "Board") authorized the closing of approximately 900 stores over the next three years. The Company expects to close approximately 300 stores each year between 2022 and 2024. As a result, management determined that there were indicators of impairment with respect to the impacted stores' asset groups, including the associated operating lease right-of-use assets and property and equipment. A long-lived asset impairment test was performed during the fourth quarter of 2021 and the results of the impairment test indicated that the fair value of certain retail store asset groups were lower than their respective carrying values. Accordingly, in the three months ended December 31, 2021, the Company recorded a store impairment charge of approximately $1.4 billion, consisting of a write down of approximately $1.1 billion related to operating lease right-of-use assets and $261 million related to property and equipment, within the Retail/LTC segment.

There were no material impairment charges recognized on long-lived assets in the year ended December 31, 2020. During the year ended December 31, 2019, the Company recorded store impairment charges of $231 million, primarily related to operating lease right-of-use asset impairment charges.

Recoverability of Goodwill
Goodwill represents the excess of amounts paid for acquisitions over the fair value of the net identifiable assets acquired. Goodwill is subject to annual impairment reviews, or more frequent reviews if events or circumstances

indicate that the carrying value may not be recoverable. Goodwill is tested for impairment on a reporting unit basis. The impairment test is performed by comparing the reporting unit's fair value with its net book value (or carrying amount), including goodwill. The fair value of the reporting units is estimated using a combination of a discounted cash flow method and a market multiple method. If the net book value (carrying amount) of the reporting unit exceeds its fair value, the reporting unit's goodwill is considered to be impaired, and an impairment is recognized in an amount equal to the excess.

The determination of the fair value of the reporting units requires the Company to make significant assumptions and estimates. These assumptions and estimates primarily include the selection of appropriate peer group companies; control premiums and valuation multiples appropriate for acquisitions in the industries in which the Company competes; discount rates; terminal growth rates; and forecasts of revenue, operating income, depreciation and amortization, income taxes, capital expenditures and future working capital requirements. When determining these assumptions and preparing these estimates, the Company considers each reporting unit's historical results and current operating trends; consolidated revenues, profitability and cash flow results and forecasts; and industry trends. The Company's estimates can be affected by a number of factors, including general economic and regulatory conditions; the risk-free interest rate environment; the Company's market capitalization; efforts of customers and payers to reduce costs, including their prescription drug costs, and/or increase member co-payments; the continued efforts of competitors to gain market share, consumer spending patterns and the Company's ability to achieve its revenue growth projections and execute on its cost reduction initiatives.

2021 Goodwill Impairment Test

During the third quarter of 2021, the Company performed its required annual impairment tests of goodwill. The results of the impairment tests indicated an impairment of the goodwill associated with the LTC reporting unit, as the reporting unit's carrying value exceeded its fair value as of the testing date. The results of the impairment tests of the remaining reporting units indicated that there was no impairment of goodwill as of the testing date. The fair values of the reporting units with goodwill exceeded their carrying values by significant margins, with the exception of the Commercial Business reporting unit, which exceeded its carrying value by approximately 3%.

As discussed in Note 5 ‘‘Goodwill and Other Intangibles’’ included in Item 8 of this 10-K, during 2021, the LTC reporting unit has continued to face challenges that have impacted the Company's ability to grow the LTC reporting unit's business at the rate estimated when its 2020 goodwill impairment test was performed. These challenges include lower net facility admissions, net long-term care facility customer losses and the prolonged adverse impact of the COVID-19 pandemic and the emerging new variants, which resulted in more significant declines in occupancy rates experienced by the Company's long-term care facility customers than previously anticipated. During the third quarter of 2021, LTC management updated their 2021 annual forecast and submitted their long-term plan which showed deterioration in the financial results for the remainder of 2021 and beyond. The Company utilized these updated projections in performing its annual impairment test, which indicated that the fair value of the LTC reporting unit was lower than its carrying value, resulting in a $431 million goodwill impairment charge in the third quarter of 2021. The fair value of the LTC reporting unit was determined using a combination of a discounted cash flow method and a market multiple method. Subsequent to the impairment charge recorded in the third quarter of 2021, there is no remaining goodwill balance in the LTC reporting unit.

The Company has experienced declines in its Commercial Insured medical membership subsequent to the closing date of the Aetna Acquisition and may continue to do so for a number of reasons, including as a result of the competitive Commercial business environment. In addition, COVID-19 and the emerging new variants have had and may continue to have an adverse impact on medical membership in the Commercial business due to reductions in workforce at existing customers (including due to business failures) as well as reduced willingness to change benefit providers by prospective customers. The Company's fair value estimate is sensitive to significant assumptions including changes in medical membership, revenue growth rate, operating income and the discount rate. Although the Company believes the financial projections used to determine the fair value of the Commercial Business reporting unit in the third quarter of 2021 were reasonable and achievable, the challenges described above may affect the Company's ability to increase medical membership or operating income in the Commercial Business reporting unit at the rate estimated when such goodwill impairment test was performed and may continue to do so. As of December 31, 2021, the goodwill balance in the Commercial Business reporting unit was $26.5 billion.

2020 Goodwill Impairment Test

During the third quarter of 2020, the Company performed its required annual impairment test of goodwill. The results of this impairment test indicated that there was no impairment of goodwill as of the testing date. The goodwill impairment test resulted in the fair values of all of the Company's reporting units exceeding their carrying values by significant margins, with the exception of the Commercial Business and LTC reporting units, which exceeded their carrying values by approximately 6% and 12%, respectively.

2019 Goodwill Impairment Test

During the third quarter of 2019, the Company performed its required annual impairment test of goodwill. The results of this impairment test indicated that there was no impairment of goodwill as of the testing date. The goodwill impairment test resulted in the fair values of all of the Company's reporting units exceeding their carrying values by significant margins, with the exception of the Commercial Business and LTC reporting units, which exceeded their carrying values by approximately 4% and 9%, respectively.

Recoverability of Indefinite-Lived Intangible Assets
Indefinite-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that their carrying value may not be recoverable. Indefinite-lived intangible assets are tested by comparing the estimated fair value of the asset to its carrying value. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized, and the asset is written down to its estimated fair value.

The indefinite-lived intangible asset impairment loss calculation contains uncertainty since management must use judgment to estimate fair value based on the assumption that, in lieu of ownership of an intangible asset, the Company would be willing to pay a royalty in order to utilize the benefits of the asset. Fair value is estimated by discounting the hypothetical royalty payments to their present value over the estimated economic life of the asset. These estimates can be affected by a number of factors including general economic conditions, availability of market information and the profitability of the Company. There were no impairment losses recognized on indefinite-lived intangible assets in any of the years ended December 31, 2021, 2020 or 2019.

Health Care Costs Payable

At December 31, 2021 and 2020, 75% and 77% respectively, of health care costs payable are estimates of the ultimate cost of (i) services rendered to the Company's Insured members but not yet reported to the Company and (ii) claims which have been reported to the Company but not yet paid (collectively, "IBNR"). Health care costs payable also include an estimate of the cost of services that will continue to be rendered after the financial statement date if the Company is obligated to pay for such services in accordance with contractual or regulatory requirements. The remainder of health care costs payable is primarily comprised of pharmacy and capitation payables, other amounts due to providers pursuant to risk sharing agreements and accruals for state assessments. The Company develops its estimate of IBNR using actuarial principles and assumptions that consider numerous factors. See Note 1 ''Significant Accounting Policies'' included in Item 8 of this 10-K for additional information on the Company's reserving methodology.

During 2021 and 2020, the Company observed an increase in completion factors relative to those assumed at the prior year end. After considering the claims paid in 2021 and 2020 with dates of service prior to the fourth quarter of the previous year, the Company observed assumed incurred claim weighted average completion factors that were 21 and 4 basis points higher, respectively, than previously estimated, resulting in a decrease of $207 million and $35 million in 2021 and 2020, respectively, in health care costs payable that related to the prior year. The Company has considered the pattern of changes in its completion factors when determining the completion factors used in its estimates of IBNR as of December 31, 2021. However, based on historical claim experience, it is reasonably possible that the Company's estimated weighted average completion factors may vary by plus or minus 13 basis points from the Company's assumed rates, which could impact health care costs payable by approximately plus or minus $186 million pretax.

Also during 2021 and 2020, the Company observed that health care costs for claims with claim incurred dates of three months or less before the financial statement date were lower than previously estimated. Specifically, after considering the claims paid in 2021 and 2020 with claim incurred dates for the fourth quarter of the previous year, the Company observed health care costs that were 5.0% and 4.0% lower, respectively, for each fourth quarter than previously estimated, resulting in a reduction of $581 million and $394 million in 2021 and 2020, respectively, in health care costs payable that related to prior year.

Management considers historical health care cost trend rates together with its knowledge of recent events that may impact current trends when developing estimates of current health care cost trend rates. When establishing reserves as of December 31, 2021, the Company increased its assumed health care cost trend rates for the most recent three months by 1.8% from health care cost trend rates recently observed. Health care cost trend rates during the past two years have been impacted by utilization changes driven by the COVID-19 pandemic. The impact has not been uniform, with products and select geographies experiencing utilization impacts due to COVID-19 waves. Based on historical claim experience, it is reasonably possible that the Company's estimated health care cost trend rates may vary by plus or minus 3.5% from the assumed rates, which could impact health care costs payable by plus or minus $450 million pretax.

Income Taxes

The Company accounts for income taxes using the asset and liability method. Deferred tax assets and liabilities are established for any temporary differences between financial and tax reporting bases and are adjusted as needed to reflect changes in the enacted tax rates expected to be in effect when the temporary differences reverse. Such adjustments are recorded in the period

in which changes in tax laws are enacted, regardless of when they are effective. Deferred tax assets are reduced, if necessary, by a valuation allowance to the extent future realization of those losses, deductions or other tax benefits is sufficiently uncertain.
Significant judgment is required in determining the provision for income taxes and the related taxes payable and deferred tax assets and liabilities since, in the ordinary course of business, there are transactions and calculations where the ultimate tax outcome is uncertain. Additionally, the Company's tax returns are subject to audit by various domestic and foreign tax authorities that could result in material adjustments based on differing interpretations of the tax laws. Although management believes that its estimates are reasonable and are based on the best available information at the time the provision is prepared, actual results could differ from these estimates resulting in a final tax outcome that may be materially different from that which is reflected in the consolidated financial statements.

The tax benefit from an uncertain tax position is recognized only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The tax benefits recognized in the consolidated financial statements from such positions are then measured based on the largest benefit that has a greater than 50% likelihood of being realized upon settlement with the related tax authority. Interest and/or penalties related to uncertain tax positions are recognized in the income tax provision. Significant judgment is required in determining uncertain tax positions. The Company has established accruals for uncertain tax positions using its judgment and adjusts these accruals, as warranted, due to changing facts and circumstances.

New Accounting Pronouncements

See Note 1 ‘‘Significant Accounting Policies’’ included in Item 8 of this 10-K for a description of new accounting pronouncements applicable to the Company.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

The Company's earnings and financial condition are exposed to interest rate risk, credit quality risk, market valuation risk, foreign currency risk, commodity risk and operational risk.

Evaluation of Interest Rate and Credit Quality Risk

The Company manages interest rate risk by seeking to maintain a tight match between the durations of assets and liabilities when appropriate. The Company manages credit quality risk by seeking to maintain high average credit quality ratings and diversified sector exposure within its debt securities portfolio. In connection with its investment and risk management objectives, the Company also uses derivative financial instruments whose market value is at least partially determined by, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets or credit ratings/spreads. The Company's use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps. These instruments, viewed separately, subject the Company to varying degrees of interest rate, equity price and credit risk. However, when used for hedging, the Company expects these instruments to reduce overall risk.

Investments
The Company's investment portfolio supported the following products at December 31, 2021 and 2020:

In millions	**2021**	**2020**
Experience-rated products	$ 957	$ 1,037
Remaining products	25,185	22,775
Total investments	$ 26,142	$ 23,812

Investment risks associated with experience-rated products generally do not impact the Company's operating results. The risks associated with investments supporting experience-rated pension and annuity products in the large case pensions business in the Company's Corporate/Other segment are assumed by the contract holders and not by the Company (subject to, among other things, certain minimum guarantees). Assets supporting experience-rated products may be subject to contract holder or participant withdrawals.

The debt securities in the Company's investment portfolio had an average credit quality rating of A at both December 31, 2021 and 2020, with a fair value of approximately $6.7 billion and $6.3 billion rated AAA at December 31, 2021 and 2020, respectively. The fair value of debt securities that were rated below investment grade (that is, having a credit quality rating below BBB-/Baa3) was $2.3 billion and $1.9 billion at December 31, 2021 and 2020, respectively (of which 2% at both December 31, 2021 and 2020 supported experience-rated products).

At December 31, 2021 and 2020, the Company held $305 million and $321 million, respectively, of municipal debt securities that were guaranteed by third parties, representing 1% of total investments at both December 31, 2021 and 2020. These securities had an average credit quality rating of AA at both December 31, 2021 and 2020 with the guarantee. These securities had an average credit quality rating of A at both December 31, 2021 and 2020, respectively, without the guarantee. The Company does not have any significant concentration of investments with third party guarantors (either direct or indirect).

The Company generally classifies debt securities as available for sale, and carries them at fair value on the consolidated balance sheets. At both December 31, 2021 and 2020, less than 1% of debt securities were valued using inputs that reflect the Company's assumptions (categorized as Level 3 inputs in accordance with accounting principles generally accepted in the United States of America). See Note 4 "Fair Value" included in Item 8 of this 10-K for additional information on the methodologies and key assumptions used to determine the fair value of investments. For additional information related to investments, see Note 3 "Investments" included in Item 8 of this 10-K.

The Company regularly reviews debt securities in its portfolio to determine whether a decline in fair value below the cost basis or carrying value has occurred. If a debt security is in an unrealized loss position and the Company has the intent to sell the security, or it is more likely than not that the Company will have to sell the security before recovery

of its amortized cost basis, the amortized cost basis of the security is written down to its fair value and the difference is recognized in net income. If a debt security is in an unrealized loss position and the Company does not have the intent to sell and it is more likely than not that the Company will not have to sell such security before recovery of its amortized cost basis, the Company bifurcates the impairment into credit-related and non-credit related components. The amount of the credit-related component is recorded as an allowance

for credit losses and recognized in net income, and the amount of the non-credit related component is included in other comprehensive income. The impairment of debt securities is considered a critical accounting policy. See "Critical Accounting Policies - Impairments of Debt Securities" in the MD&A included in Item 7 of this 10-K for additional information.

Evaluation of Market Valuation Risks

The Company regularly evaluates its risk from market-sensitive instruments by examining, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets and/or credit ratings/spreads. The Company also regularly evaluates the appropriateness of investments relative to management-approved investment guidelines (and operates within those guidelines) and the business objectives of its portfolios.

On a quarterly basis, the Company reviews the impact of hypothetical net losses in its investment portfolio on the Company's consolidated near-term financial condition, operating results and cash flows assuming the occurrence of certain reasonably possible changes in near-term market rates and prices. Interest rate changes (whether resulting from changes in treasury yields or credit spreads or other factors) represent the most material risk exposure category for the Company. The Company has estimated the impact on the fair value of market sensitive instruments based on the net present value of cash flows using a representative set of likely future interest rate scenarios. The assumptions used were as follows: an immediate increase of 100 basis points in interest rates (which the Company believes represents a moderately adverse scenario) for long-term debt issued by the Company, as well as its interest rate sensitive investments and an immediate decrease of 15% in prices for publicly traded domestic equity securities in the Company's investment portfolio.

Assuming an immediate increase of 100 basis points in interest rates, the theoretical decline in the fair values of market sensitive instruments at December 31, 2021 is as follows:

- The fair value of long-term debt issued by the Company would decline by approximately $4.6 billion ($5.8 billion pretax). Changes in the fair value of long-term debt do not impact the Company's operating results or financial condition.
- The theoretical reduction in the fair value of interest rate sensitive investments partially offset by the theoretical reduction in the fair value of interest rate sensitive liabilities would result in a net decline in fair value of approximately $680 million ($860 million pretax) related to continuing non-experience-rated products. Reductions in the fair value of investment securities would be reflected as an unrealized loss in equity, as the Company classifies these debt securities as available for sale. The Company does not record liabilities at fair value.

If the value of the Company's publicly traded domestic equity securities held within its investment portfolio were to decline by 15%, this would result in a net decline in fair value of $14 million ($18 million pretax).

Based on overall exposure to interest rate risk and equity price risk, the Company believes that these changes in market rates and prices would not materially affect consolidated near-term financial condition, operating results or cash flows as of December 31, 2021.

Evaluation of Foreign Currency and Commodity Risk

At December 31, 2021 and 2020, the Company did not have any material foreign currency exchange rate or commodity derivative instruments in place and believes its exposure to foreign currency exchange rate risk is not material.

Evaluation of Operational Risks

The Company also faces certain operational risks. Those risks include risks related to the COVID-19 pandemic and risks related to information security, including cybersecurity.

The spread of COVID-19, or actions taken to mitigate its spread, could have material and adverse effects on our ability to operate our businesses effectively, including as a result of the complete or partial closure of facilities or

labor shortages. Disruptions in our supply chains, our distribution chains and/or public and private infrastructure, including communications, financial services and supply chains, could materially and adversely impact our business operations. We have transitioned a significant subset of our colleagues to a remote work environment in an effort to mitigate the spread of COVID-19, as have a significant number of our third-party service providers, which may amplify certain risks to our businesses, including an increased demand for information technology resources, increased risk of phishing and other cyber attacks, increased risk of unauthorized dissemination of sensitive personal information or proprietary or confidential information about us or our medical members or other third-parties and increased risk of business interruptions.

The Company and its vendors have experienced diverse cyber attacks and expect to continue to experience cyber attacks going forward. As examples, the Company and its vendors have experienced attempts to gain access to systems, denial of service attacks, attempted malware infections, account takeovers, scanning activity and phishing emails. Attacks can originate from external criminals, terrorists, nation states or internal actors. The Company is dedicating and will continue to dedicate significant resources and incur significant expenses to maintain and update on an ongoing basis the systems and processes that are designed to mitigate the information security risks it faces and protect the security of its computer systems, software, networks and other technology assets against attempts by unauthorized parties to obtain access to confidential information, disrupt or degrade service or cause other damage. The impact of cyber attacks has not been material to the Company's operations or operating results through December 31, 2021. The Board and its Audit Committee and Nominating and Corporate Governance Committee are regularly informed regarding the Company's information security policies, practices and status.

Item 8. Financial Statements and Supplementary Data.

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Consolidated Statements of Operations

In millions, except per share amounts	For the Years Ended December 31, 2021	2020	2019
Revenues:			
Products	$ 203,738	$ 190,688	$ 185,236
Premiums	76,132	69,364	63,122
Services	11,042	7,856	7,407
Net investment income	1,199	798	1,011
Total revenues	292,111	268,706	256,776
Operating costs:			
Cost of products sold	175,803	163,981	158,719
Benefit costs	64,260	55,679	52,529
Store impairments	1,358	—	231
Goodwill impairment	431	—	—
Operating expenses	37,066	35,135	33,310
Total operating costs	278,918	254,795	244,789
Operating income	13,193	13,911	11,987
Interest expense	2,503	2,907	3,035
Loss on early extinguishment of debt	452	1,440	79
Other income	(182)	(206)	(124)
Income before income tax provision	10,420	9,770	8,997
Income tax provision	2,522	2,569	2,366
Income from continuing operations	7,898	7,201	6,631
Loss from discontinued operations, net of tax	—	(9)	—
Net income	7,898	7,192	6,631
Net (income) loss attributable to noncontrolling interests	12	(13)	3
Net income attributable to CVS Health	$ 7,910	$ 7,179	$ 6,634
Basic earnings per share:			
Income from continuing operations attributable to CVS Health	$ 6.00	$ 5.49	$ 5.10
Loss from discontinued operations attributable to CVS Health	$ —	$ (0.01)	$ —
Net income attributable to CVS Health	$ 6.00	$ 5.48	$ 5.10
Weighted average basic shares outstanding	1,319	1,309	1,301
Diluted earnings per share:			
Income from continuing operations attributable to CVS Health	$ 5.95	$ 5.47	$ 5.08
Loss from discontinued operations attributable to CVS Health	$ —	$ (0.01)	$ —
Net income attributable to CVS Health	$ 5.95	$ 5.46	$ 5.08
Weighted average diluted shares outstanding	1,329	1,314	1,305
Dividends declared per share	$ 2.00	$ 2.00	$ 2.00

See accompanying notes to consolidated financial statements.

Consolidated Statements of Comprehensive Income

In millions	For the Years Ended December 31, 2021	2020	2019
Net income	$ 7,898	$ 7,192	$ 6,631
Other comprehensive income (loss), net of tax:			
Net unrealized investment gains (losses)	(436)	440	677
Foreign currency translation adjustments	(7)	3	162
Net cash flow hedges	(26)	(31)	(33)
Pension and other postretirement benefits	20	(17)	111
Other comprehensive income (loss)	(449)	395	917
Comprehensive income	7,449	7,587	7,548
Comprehensive (income) loss attributable to noncontrolling interests	12	(13)	3
Comprehensive income attributable to CVS Health	$ 7,461	$ 7,574	$ 7,551

See accompanying notes to consolidated financial statements.

Index to Consolidated Financial Statements

Consolidated Balance Sheets

In millions, except per share amounts	At December 31, 2021	2020
Assets:		
Cash and cash equivalents	$ 9,408	$ 7,854
Investments	3,117	3,000
Accounts receivable, net	24,431	21,742
Inventories	17,760	18,496
Other current assets	5,292	5,277
Total current assets	60,008	56,369
Long-term investments	23,025	20,812
Property and equipment, net	12,896	12,606
Operating lease right-of-use assets	19,122	20,729
Goodwill	79,121	79,552
Intangible assets, net	29,026	31,142
Separate accounts assets	5,087	4,881
Other assets	4,714	4,624
Total assets	$ 232,999	$ 230,715
Liabilities:		
Accounts payable	$ 12,544	$ 11,138
Pharmacy claims and discounts payable	17,330	15,795
Health care costs payable	8,808	7,936
Policyholders' funds	4,301	4,270
Accrued expenses	17,670	14,243
Other insurance liabilities	1,303	1,557
Current portion of operating lease liabilities	1,646	1,638
Current portion of long-term debt	4,205	5,440
Total current liabilities	67,807	62,017
Long-term operating lease liabilities	18,177	18,757
Long-term debt	51,971	59,207
Deferred income taxes	6,270	6,794
Separate accounts liabilities	5,087	4,881
Other long-term insurance liabilities	6,402	7,007
Other long-term liabilities	1,904	2,351
Total liabilities	157,618	161,014
Commitments and contingencies (Note 16)		
Shareholders' equity:		
Preferred stock, par value $0.01: 0.1 shares authorized; none issued or outstanding	—	—
Common stock, par value $0.01: 3,200 shares authorized; 1,744 shares issued and 1,322 shares outstanding at December 31, 2021 and 1,733 shares issued and 1,310 shares outstanding at December 31, 2020 and capital surplus	47,377	46,513
Treasury stock, at cost: 422 and 423 shares at December 31, 2021 and 2020	(28,173)	(28,178)
Retained earnings	54,906	49,640
Accumulated other comprehensive income	965	1,414
Total CVS Health shareholders' equity	75,075	69,389
Noncontrolling interests	306	312
Total shareholders' equity	75,381	69,701
Total liabilities and shareholders' equity	$ 232,999	$ 230,715

See accompanying notes to consolidated financial statements.

Consolidated Statements of Cash Flows

In millions	For the Years Ended December 31, 2021	2020	2019
Cash flows from operating activities:			
Cash receipts from customers	$ 284,219	$ 264,327	$ 248,393
Cash paid for inventory and prescriptions dispensed by retail network pharmacies	(165,783)	(158,636)	(149,655)
Insurance benefits paid	(63,598)	(55,124)	(52,242)
Cash paid to other suppliers and employees	(31,652)	(29,763)	(28,932)
Interest and investment income received	743	894	955
Interest paid	(2,469)	(2,904)	(2,954)
Income taxes paid	(3,195)	(2,929)	(2,717)
Net cash provided by operating activities	18,265	15,865	12,848
Cash flows from investing activities:			
Proceeds from sales and maturities of investments	7,246	6,467	7,049
Purchases of investments	(9,963)	(9,639)	(7,534)
Purchases of property and equipment	(2,520)	(2,437)	(2,457)
Proceeds from sale-leaseback transactions	—	101	5
Acquisitions (net of cash acquired)	(146)	(866)	(444)
Proceeds from sale of subsidiary	—	840	—
Other	122	—	42
Net cash used in investing activities	(5,261)	(5,534)	(3,339)
Cash flows from financing activities:			
Net repayments of short-term debt	—	—	(720)
Proceeds from issuance of long-term debt	987	9,958	3,736
Repayments of long-term debt	(10,254)	(15,631)	(8,336)
Derivative settlements	—	(7)	(25)
Dividends paid	(2,625)	(2,624)	(2,603)
Proceeds from exercise of stock options	549	264	210
Payments for taxes related to net share settlement of equity awards	(168)	(88)	(112)
Other	155	432	196
Net cash used in financing activities	(11,356)	(7,696)	(7,654)
Net increase in cash, cash equivalents and restricted cash	1,648	2,635	1,855
Cash, cash equivalents and restricted cash at the beginning of the period	11,043	8,408	6,553
Cash, cash equivalents and restricted cash at the end of the period	$ 12,691	$ 11,043	$ 8,408

	For the Years Ended December 31,		
In millions	**2021**	**2020**	**2019**
Reconciliation of net income to net cash provided by operating activities:			
Net income	$ 7,898	$ 7,192	$ 6,631
Adjustments required to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	4,512	4,441	4,371
Store impairments	1,358	—	231
Goodwill impairment	431	—	—
Stock-based compensation	484	400	453
(Gain) loss on sale of subsidiaries	—	(269)	205
Loss on early extinguishment of debt	452	1,440	79
Deferred income taxes	(428)	(570)	(654)
Other noncash items	(390)	72	33
Change in operating assets and liabilities, net of effects from acquisitions:			
Accounts receivable, net	(2,703)	(1,510)	(2,158)
Inventories	735	(973)	(1,075)
Other assets	(3)	364	(614)
Accounts payable and pharmacy claims and discounts payable	2,898	2,769	3,550
Health care costs payable and other insurance liabilities	169	(231)	320
Other liabilities	2,852	2,740	1,476
Net cash provided by operating activities	$ 18,265	$ 15,865	$ 12,848

See accompanying notes to consolidated financial statements.

Consolidated Statements of Shareholders' Equity

	Number of shares outstanding		Attributable to CVS Health						
In millions	Common Shares	Treasury Shares [1]	Common Stock and Capital Surplus [2]	Treasury Stock [1]	Retained Earnings	Accumulated Other Comprehensive Income	Total CVS Health Shareholders' Equity	Noncontrolling Interests	Total Shareholders' Equity
Balance at December 31, 2018	**1,720**	**(425)**	**$ 45,440**	**$ (28,228)**	**$ 40,911**	**$ 102**	**$ 58,225**	**$ 318**	**$ 58,543**
Adoption of new accounting standards [3]	—	—	—	—	178	—	178	—	178
Net income	—	—	—	—	6,634	—	6,634	(3)	6,631
Other comprehensive income (Note 13)	—	—	—	—	—	917	917	—	917
Stock option activity, stock awards and other	7	2	532	—	—	—	532	—	532
Purchase of treasury shares, net of ESPP issuances	—	(2)	—	(7)	—	—	(7)	—	(7)
Common stock dividends	—	—	—	—	(2,615)	—	(2,615)	—	(2,615)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(9)	(9)
Balance at December 31, 2019	1,727	(425)	45,972	(28,235)	45,108	1,019	63,864	306	64,170
Adoption of new accounting standard [4]	—	—	—	—	(3)	—	(3)	—	(3)
Net income	—	—	—	—	7,179	—	7,179	13	7,192
Other comprehensive income (Note 13)	—	—	—	—	—	395	395	—	395
Stock option activity, stock awards and other	6	—	541	—	—	—	541	—	541
ESPP issuances, net of purchase of treasury shares	—	2	—	57	—	—	57	—	57
Common stock dividends	—	—	—	—	(2,644)	—	(2,644)	—	(2,644)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(7)	(7)
Balance at December 31, 2020	1,733	(423)	46,513	(28,178)	49,640	1,414	69,389	312	69,701
Net income	—	—	—	—	7,910	—	7,910	(12)	7,898
Other comprehensive loss (Note 13)	—	—	—	—	—	(449)	(449)	—	(449)
Stock option activity, stock awards and other	11	—	864	—	—	—	864	—	864
ESPP issuances, net of purchase of treasury shares	—	1	—	5	—	—	5	—	5
Common stock dividends	—	—	—	—	(2,644)	—	(2,644)	—	(2,644)
Other increases in noncontrolling interests	—	—	—	—	—	—	—	6	6
Balance at December 31, 2021	**1,744**	**(422)**	**$ 47,377**	**$ (28,173)**	**$ 54,906**	**$ 965**	**$ 75,075**	**$ 306**	**$ 75,381**

(1) Treasury shares include 1 million shares held in trust for each of the years ended December 31, 2021, 2020 and 2019. Treasury stock includes $29 million related to shares held in trust for each of the years ended December 31, 2021, 2020 and 2019. See Note 1 ‘‘Significant Accounting Policies’’ for additional information.
(2) Common stock and capital surplus includes the par value of common stock of $17 million as of December 31, 2021, 2020 and 2019.
(3) Reflects the adoption of Accounting Standards Update (“ASU”) 2016-02, *Leases* (Topic 842), which resulted in an increase to retained earnings of $178 million during the year ended December 31, 2019.
(4) Reflects the adoption of ASU 2016-13, *Financial Instruments - Credit Losses* (Topic 326), which resulted in a reduction to retained earnings of $3 million during the year ended December 31, 2020.

See accompanying notes to consolidated financial statements.

Notes to Consolidated Financial Statements

1. Significant Accounting Policies

Description of Business

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health" or the "Company"), has more than 9,900 retail locations, nearly 1,200 walk-in medical clinics, a leading pharmacy benefits manager with approximately 110 million plan members with expanding specialty pharmacy solutions and a dedicated senior pharmacy care business serving more than one million patients per year. The Company also serves an estimated 35 million people through traditional, voluntary and consumer-directed health insurance products and related services, including expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

The coronavirus disease 2019 ("COVID-19") and its emerging new variants continue to impact the economies of the U.S. and other countries around the world. The impact of COVID-19 on the Company's businesses, operating results, cash flows and financial condition in the years ended December 31, 2021 and 2020, as well as information regarding certain expected impacts of COVID-19 on the Company, is discussed throughout this Annual Report on Form 10-K.

The Company has four reportable segments: Health Care Benefits, Pharmacy Services, Retail/LTC and Corporate/ Other, which are described below.

Health Care Benefits Segment
The Health Care Benefits segment operates as one of the nation's leading diversified health care benefits providers. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make more informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental and behavioral health plans, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services and health information technology products and services. The Health Care Benefits segment also provided workers' compensation administrative services through its Coventry Health Care Workers' Compensation business ("Workers' Compensation business") prior to the sale of this business on July 31, 2020. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates. The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk for medical and dental care costs) as "ASC." In addition, effective January 2022, the Company entered the individual public health insurance exchanges ("Public Exchanges") in eight states through which it sells Insured plans directly to individual consumers.

Pharmacy Services Segment
The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services and mail order pharmacy. In addition, through the Pharmacy Services segment, the Company provides specialty pharmacy and infusion services, clinical services, disease management services, medical spend management and pharmacy and/or other administrative services for providers and federal 340B drug pricing program covered entities ("Covered Entities"). The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Medicaid managed care plans, plans offered on Public Exchanges and private health insurance exchanges, other sponsors of health benefit plans throughout the United States and Covered Entities. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services.

Retail/LTC Segment
The Retail/LTC segment sells prescription drugs and a wide assortment of health and wellness products and general merchandise, provides health care services through its MinuteClinic® walk-in medical clinics, provides medical

diagnostic testing, administers vaccinations for illnesses such as influenza, COVID-19 and shingles and conducts long-term care pharmacy ("LTC") operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to long-term care facilities and other care settings. As of December 31, 2021, the Retail/LTC segment operated more than 9,900 retail locations, nearly 1,200 MinuteClinic locations as well as online retail pharmacy websites, LTC pharmacies and on-site pharmacies.

Corporate/Other Segment
The Company presents the remainder of its financial results in the Corporate/Other segment, which primarily consists of:

- Management and administrative expenses to support the Company's overall operations, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments, expenses associated with the Company's investments in its transformation and enterprise modernization programs and acquisition-related transaction and integration costs; and
- Products for which the Company no longer solicits or accepts new customers such as its large case pensions and long-term care insurance products.

Basis of Presentation

The accompanying consolidated financial statements of CVS Health and its subsidiaries have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP"). The consolidated financial statements include the accounts of the Company and its majority-owned subsidiaries and variable interest entities ("VIEs") for which the Company is the primary beneficiary. All material intercompany balances and transactions have been eliminated.

Reclassifications

Certain prior year amounts have been reclassified to conform with the current year presentation.

Use of Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and temporary investments with maturities of three months or less when purchased. The Company invests in short-term money market funds, commercial paper and time deposits, as well as other debt securities that are classified as cash equivalents within the accompanying consolidated balance sheets, as these funds are highly liquid and readily convertible to known amounts of cash.

Restricted Cash

Restricted cash (included in other current assets) represents funds held on behalf of members, including health savings account ("HSA") funds associated with high deductible health plans. Beginning in 2021, the Company began presenting these funds held on behalf of members in restricted cash and, for statement of cash flow purposes, retrospectively adjusted the 2020 and 2019 balances by the amounts shown in the table below in the line item "restricted cash (included in other current assets)" to conform with the current year presentation. Restricted cash (included in other assets) represents amounts held in a trust in one of the Company's captive insurance companies to satisfy collateral requirements associated with the assignment of certain insurance policies. All restricted cash is invested in time deposits, money market funds or commercial paper.

The following is a reconciliation of cash and cash equivalents on the consolidated balance sheets to total cash, cash equivalents and restricted cash on the consolidated statements of cash flows as of December 31, 2021, 2020 and 2019:

In millions	**2021**	**2020**	**2019**
Cash and cash equivalents	$ 9,408	$ 7,854	$ 5,683
Restricted cash (included in other current assets)	3,065	2,913	2,454
Restricted cash (included in other assets)	218	276	271
Total cash, cash equivalents and restricted cash in the consolidated statements of cash flows	$ 12,691	$ 11,043	$ 8,408

Investments

Debt Securities
Debt securities consist primarily of U.S. Treasury and agency securities, mortgage-backed securities, corporate and foreign bonds and other debt securities. Debt securities are classified as either current or long-term investments based on their contractual maturities unless the Company intends to sell an investment within the next twelve months, in which case it is classified as current on the consolidated balance sheets. Debt securities are classified as available for sale and are carried at fair value. See Note 4 ‘‘Fair Value’’ for additional information on how the Company estimates the fair value of these investments.

If a debt security is in an unrealized loss position and the Company has the intent to sell the security, or it is more likely than not that the Company will have to sell the security before recovery of its amortized cost basis, the amortized cost basis of the security is written down to its fair value and the difference is recognized in net income. If a debt security is in an unrealized loss position and the Company does not have the intent to sell and it is more likely than not that the Company will not have to sell such security before recovery of its amortized cost basis, the Company bifurcates the impairment into credit-related and non-credit related components. In evaluating whether a credit related loss exists, the Company considers a variety of factors including: the extent to which the fair value is less than the amortized cost basis; adverse conditions specifically related to the issuer of a security, an industry or geographic area; the payment structure of the security; the failure of the issuer of the security to make scheduled interest or principal payments; and any changes to the rating of the security by a rating agency. The amount of the credit-related component is recorded as an allowance for credit losses and recognized in net income, and the amount of the non-credit related component is included in other comprehensive income. Interest is not accrued on debt securities when management believes the collection of interest is unlikely.

The credit-related component is determined by comparing the present value of cash flows expected to be collected from the security, considering all reasonably available information relevant to the collectability of the security, with the amortized cost basis of the security. If the present value of cash flows expected to be collected is less than the amortized cost basis of the security, the Company records an allowance for credit losses, which is limited by the amount that the fair value is less than amortized cost basis.

For mortgage-backed and other asset-backed securities, the Company recognizes income using an effective yield based on anticipated prepayments and the estimated economic life of the securities. When estimates of prepayments change, the effective yield is recalculated to reflect actual payments to date and anticipated future payments. The Company’s investment in the security is adjusted to the amount that would have existed had the new effective yield been applied since the acquisition of the security, with adjustments recognized in net income.

Equity Securities
Equity securities with readily available fair values are measured at fair value with changes in fair value recognized in net income (loss).

Mortgage Loans
Mortgage loan investments on the consolidated balance sheets are valued at the unpaid principal balance, net of an allowance for credit losses. Mortgage loans with a maturity date or a committed prepayment date within twelve months are classified as current on the consolidated balance sheets. The Company assesses whether its loans share similar risk characteristics and, if so, groups such loans in a risk pool when measuring expected credit losses. The Company considers the following characteristics when evaluating whether its loans share similar risk characteristics: loan-to-value ratios, property type (e.g., office, retail, apartment, industrial), geographic location, vacancy rates and property condition.

Credit loss reserves are determined using a loss rate method that multiplies the unpaid principal balance of each loan within a risk pool group by an estimated loss rate percentage. The loss rate percentage considers both the expected loan loss severity and the probability of loan default. For periods where the Company is able to make or obtain reasonable and supportable forecasts of expected economic conditions (e.g., gross domestic product, employment), the Company adjusts its expected loss rates to reflect these forecasted economic conditions. For periods beyond which the Company is able to make or obtain reasonable and supportable forecasts of expected economic conditions, the Company reverts to historical loss rates in determining expected credit losses.

Interest income on a potential problem loan (i.e., high probability of default) or restructured loan is accrued to the extent it is deemed to be collectible and the loan continues to perform under its original or restructured terms. Interest income on problem loans (i.e., more than 60 days delinquent, in bankruptcy or in process of foreclosure) is recognized on a cash basis. Cash payments on loans in the process of foreclosure are treated as a return of principal.

Other Investments
Other investments consist primarily of the following:

- Private equity and hedge fund limited partnerships, which are accounted for using the equity method of accounting. Under this method, the carrying value of the investment is based on the value of the Company's equity ownership of the underlying investment funds provided by the general partner or manager of the investments, the financial statements of which generally are audited. As a result of the timing of the receipt of the valuation information provided by the fund managers, these investments are generally reported on up to a three month lag. The Company reviews investments for impairment at least quarterly and monitors their performance throughout the year through discussions with the administrators, managers and/or general partners. If the Company becomes aware of an impairment of a limited partnership's investments through its review or prior to receiving the limited partnership's financial statements at the financial statement date, an impairment will be recognized by recording a reduction in the carrying value of the limited partnership with a corresponding charge to net investment income.
- Investment real estate, which is carried on the consolidated balance sheets at depreciated cost, including capital additions, net of write-downs for other-than-temporary declines in fair value. Depreciation is calculated using the straight-line method based on the estimated useful life of each asset. If any real estate investment is considered held-for-sale, it is carried at the lower of its carrying value or fair value less estimated selling costs. The Company generally estimates fair value using net operating income and applying a capitalization rate in conjunction with comparable sales information. At the time of the sale, the difference between the sales price and the carrying value is recorded as a realized capital gain or loss.
- Privately-placed equity securities, which are carried on the consolidated balance sheets at cost less impairments, plus or minus subsequent adjustments for observable price changes. Additionally, as a member of the Federal Home Loan Bank of Boston ("FHLBB"), a subsidiary of the Company is required to purchase and hold shares of the FHLBB. These shares are restricted and carried at cost.

Net Investment Income
Net investment income on the Company's investments is recorded when earned and is reflected in the Company's net income (other than net investment income on assets supporting experience-rated products). Experience-rated products are products in the large case pensions business where the contract holder, not the Company, assumes investment and other risks, subject to, among other things, minimum guarantees provided by the Company. The effect of investment performance on experience-rated products is allocated to contract holders' accounts daily, based on the underlying investment experience and, therefore, does not impact the Company's net income (as long as the contract's minimum guarantees are not triggered). Net investment income on assets supporting large case pensions' experience-rated products is included in net investment income in the consolidated statements of operations and is credited to contract holders' accounts through a charge to benefit costs. The contract holders' accounts are reflected in policyholders' funds on the consolidated balance sheets.

Realized capital gains and losses on investments (other than realized capital gains and losses on investments supporting experience-rated products) are included as a component of net investment income in the consolidated statements of operations. Realized capital gains and losses are determined on a specific identification basis. Purchases and sales of debt and equity securities and alternative investments are reflected on the trade date. Purchases and sales of mortgage loans and investment real estate are reflected on the closing date.

Realized capital gains and losses on investments supporting large case pensions' experience-rated products are not included in realized capital gains and losses in the consolidated statements of operations and instead are credited directly to contract holders' accounts. The contract holders' accounts are reflected in policyholders' funds on the consolidated balance sheets.

Unrealized capital gains and losses on investments (other than unrealized capital gains and losses on investments supporting experience-rated products) are reflected in shareholders' equity, net of tax, as a component of accumulated other comprehensive income. Unrealized capital gains and losses on investments supporting large case pensions' experience-rated products are credited directly to contract holders' accounts. The contract holders' accounts are reflected in policyholders' funds on the consolidated balance sheets.

Derivative Financial Instruments

The Company uses derivative financial instruments in order to manage interest rate and foreign exchange risk and credit exposure. The Company's use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps.

Accounts Receivable

Accounts receivable are stated net of allowances for credit losses, customer credit allowances, contractual allowances and estimated terminations. Accounts receivable, net is composed of the following at December 31, 2021 and 2020:

In millions	2021	2020
Trade receivables	$ 7,932	$ 7,101
Vendor and manufacturer receivables	10,573	9,815
Premium receivables	2,537	2,628
Other receivables	3,389	2,198
Total accounts receivable, net	$ 24,431	$ 21,742

The Company's allowance for credit losses was $339 million and $358 million as of December 31, 2021 and 2020, respectively. When developing an estimate of the Company's expected credit losses, the Company considers all available relevant information regarding the collectability of cash flows, including historical information, current conditions and reasonable and supportable forecasts of future economic conditions over the contractual life of the receivable. The Company's accounts receivable are short duration in nature and typically settle in less than 30 days.

Inventories

Inventories are valued at the lower of cost or net realizable value using the weighted average cost method. Physical inventory counts are taken on a regular basis in each retail store and LTC pharmacy, and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the consolidated financial statements are properly stated. During the interim period between physical inventory counts, the Company accrues for anticipated physical inventory losses on a location-by-location basis based on historical results and current physical inventory trends.

Reinsurance Recoverables

The Company utilizes reinsurance agreements primarily to: (a) reduce required capital and (b) facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit the Company to recover a portion of its losses from reinsurers, although they do not discharge the Company's primary liability as the direct insurer of the risks reinsured. Failure of reinsurers to indemnify the Company could result in losses; however, the Company does not expect charges for unrecoverable reinsurance to have a material effect on its consolidated operating results or financial condition. The Company evaluates the financial condition of its reinsurers and monitors concentrations of credit risk arising from similar geographic regions, activities or economic characteristics of its reinsurers. At December 31, 2021, the Company's reinsurance recoverables consisted primarily of amounts due from third parties that are rated consistent with companies that are considered to have the ability to meet their obligations. Reinsurance recoverables are recorded as other current assets or other assets on the consolidated balance sheets.

Health Care Contract Acquisition Costs

Insurance products included in the Health Care Benefits segment are cancellable by either the customer or the member monthly upon written notice. Acquisition costs related to prepaid health care and health indemnity contracts are generally expensed as incurred. Acquisition costs for certain long-duration insurance contracts are deferred and are recorded as other current assets or other assets on the consolidated balance sheets and are amortized over the estimated life of the contracts. The amortization of deferred acquisition costs is recorded in operating expenses in the consolidated statements of operations. At December 31, 2021 and 2020, the balance of deferred acquisition costs was $895 million and $546 million, respectively, comprised primarily of commissions paid on Medicare Supplement products within the Health Care Benefits segment.

Property and Equipment

Property and equipment is reported at historical cost, net of accumulated depreciation. Property, equipment and improvements to leased premises are depreciated using the straight-line method over the estimated useful lives of the assets, or when applicable, the term of the lease, whichever is shorter. Estimated useful lives generally range from 1

to 40 years for buildings, building improvements and leasehold improvements and 3 to 10 years for fixtures, equipment and internally developed software. Repair and maintenance costs are charged directly to expense as incurred. Major renewals or replacements that

substantially extend the useful life of an asset are capitalized and depreciated. Application development stage costs for significant internally developed software projects are capitalized and depreciated.

Property and equipment consists of the following at December 31, 2021 and 2020:

In millions	**2021**	**2020**
Land	$ 2,038	$ 2,134
Building and improvements	4,225	3,950
Fixtures and equipment	13,619	13,125
Leasehold improvements	6,242	6,077
Software	7,426	6,020
Total property and equipment	33,550	31,306
Accumulated depreciation and amortization	(20,654)	(18,700)
Property and equipment, net	$ 12,896	$ 12,606

Depreciation expense (which includes the amortization of property and equipment under finance or capital leases) totaled $2.3 billion, $2.1 billion and $1.9 billion for the years ended December 31, 2021, 2020 and 2019, respectively. During the year ended December 31, 2021, the Company recorded an impairment on property and equipment of $261 million in connection with the planned closure of certain retail stores. See Note 6 ‘‘Leases’’ for additional information about this impairment charge as well as the Company’s finance leases.

Right-of-Use Assets and Lease Liabilities

The Company determines if an arrangement contains a lease at the inception of a contract. Right-of-use assets represent the Company’s right to use an underlying asset for the lease term and lease liabilities represent the Company’s obligation to make lease payments arising from the lease. Right-of-use assets and lease liabilities are recognized at the commencement date of the lease, renewal date of the lease or significant remodeling of the lease space based on the present value of the remaining future minimum lease payments. As the interest rate implicit in the Company’s leases is not readily determinable, the Company utilizes its incremental borrowing rate, determined by class of underlying asset, to discount the lease payments. The operating lease right-of-use assets also include lease payments made before commencement and are reduced by lease incentives.

The Company’s real estate leases typically contain options that permit renewals for additional periods of up to five years each. For real estate leases, the options to extend are not considered reasonably certain at lease commencement because the Company reevaluates each lease on a regular basis to consider the economic and strategic incentives of exercising the renewal options and regularly opens or closes stores to align with its operating strategy. Generally, the renewal option periods are not included within the lease term and the associated payments are not included in the measurement of the right-of-use asset and lease liability. Similarly, renewal options are not included in the lease term for non-real estate leases because they are not considered reasonably certain of being exercised at lease commencement. Leases with an initial term of 12 months or less are not recorded on the balance sheets, and lease expense is recognized on a straight-line basis over the term of the short-term lease.

For real estate leases, the Company accounts for lease components and nonlease components as a single lease component. Certain real estate leases require additional payments based on sales volume, as well as reimbursement for real estate taxes, common area maintenance and insurance, which are expensed as incurred as variable lease costs. Other real estate leases contain one fixed lease payment that includes real estate taxes, common area maintenance and insurance. These fixed payments are considered part of the lease payment and included in the right-of-use assets and lease liabilities.

See Note 6 ‘‘Leases’’ for additional information about right-of-use assets and lease liabilities.

Goodwill

The Company accounts for business combinations using the acquisition method of accounting, which requires the excess cost of an acquisition over the fair value of net assets acquired and identifiable intangible assets to be recorded

as goodwill. Goodwill is not amortized, but is subject to impairment reviews annually, or more frequently if necessary, as further described in “Long-Lived Asset Impairment” below. See Note 5 ‘‘Goodwill and Other Intangibles’’ for additional information about goodwill.

Intangible Assets

The Company's identifiable intangible assets consist primarily of trademarks, trade names, customer contracts/ relationships, covenants not to compete, technology, provider networks and value of business acquired ("VOBA"). These intangible assets arise primarily from the determination of their respective fair market values at the date of acquisition. Amounts assigned to identifiable intangible assets, and their related useful lives, are derived from established valuation techniques and management estimates.

The Company's definite-lived intangible assets are amortized over their estimated useful lives based upon the pattern of future cash flows attributable to the asset. Other than VOBA, definite-lived intangible assets are amortized using the straight-line method. VOBA is amortized over the expected life of the acquired contracts in proportion to estimated premiums. Indefinite-lived intangible assets are not amortized but are tested for impairment annually, or more frequently if necessary, as further described in "Long-Lived Asset Impairment" below.

See Note 5 ''Goodwill and Other Intangibles'' for additional information about intangible assets.

Long-Lived Asset Impairment

The Company evaluates the recoverability of long-lived assets, excluding goodwill and indefinite-lived intangible assets, which are tested for impairment using separate tests described below, whenever events or changes in circumstances indicate that the carrying value of such asset may not be recoverable. The Company groups and evaluates these long-lived assets for impairment at the lowest level at which individual cash flows can be identified. If indicators of impairment are present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted). If the estimated future cash flows used in this analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group's estimated future cash flows (discounted). If required, an impairment loss is recorded for the portion of the asset group's carrying value that exceeds the asset group's estimated future cash flows (discounted). During the year ended December 31, 2021, the Company recorded a store impairment charge of approximately $1.4 billion primarily related to the write down of operating lease right-of-use assets and property and equipment in connection with the planned closure of approximately 900 retail stores between 2022 and 2024. There were no material impairment charges recognized on long-lived assets in the year ended 2020. During the year ended December 31, 2019 the Company recorded a store impairment charge of $231 million primarily related to operating lease right-of-use assets. See Note 6 ''Leases'' for additional information about the right-of-use asset impairment charges.

When evaluating goodwill for potential impairment, the Company compares the fair value of its reporting units to their respective carrying amounts. The Company estimates the fair value of its reporting units using a combination of a discounted cash flow method and a market multiple method. If the carrying amount of a reporting unit exceeds its estimated fair value, an impairment loss is recognized in an amount equal to that excess. During the third quarter of 2021, the Company performed its required annual impairment tests of goodwill, the results of which indicated an impairment of the goodwill associated with the LTC reporting unit. Accordingly, during the third quarter of 2021, the Company recorded a $431 million goodwill impairment charge. The results of the impairment tests indicated that there was no impairment of goodwill of the remaining reporting units as of the testing date or during the year ended December 31, 2021. During the third quarter of both 2020 and 2019, the Company performed its required annual goodwill impairment tests and concluded there were no goodwill impairments as of the testing dates or during the years ended December 31, 2020 and 2019. See Note 5 ''Goodwill and Other Intangibles'' for additional information about the goodwill impairment charge recorded during the year ended December 31, 2021.

Indefinite-lived intangible assets are tested for impairment by comparing the estimated fair value of the asset to its carrying value. The Company estimates the fair value of its indefinite-lived trademarks using the relief from royalty method under the income approach. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized, and the asset is written down to its estimated fair value. There were no impairment losses recognized on indefinite-lived intangible assets in any of the years ended December 31, 2021, 2020 or 2019.

Separate Accounts

Separate Accounts assets and liabilities related to large case pensions products represent funds maintained to meet specific objectives of contract holders who bear the investment risk. These assets and liabilities are carried at fair value. Net investment income (including net realized capital gains and losses) accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from the Company's other businesses. Deposits, withdrawals and net

investment income (including net realized and net unrealized capital gains and losses) on Separate Accounts assets are not reflected in the consolidated statements of operations or cash flows. Management fees charged to contract holders are included in services revenue and recognized over the period earned.

Health Care Costs Payable

Health care costs payable consist principally of unpaid fee-for-service medical, dental and pharmacy claims, capitation costs, other amounts due to providers pursuant to risk-sharing arrangements related to the Health Care Benefits segment's Insured Commercial, Medicare and Medicaid products and accruals for state assessments. Unpaid health care claims include an estimate of payments the Company will make for (i) services rendered to the Company's Insured members but not yet reported to the Company and (ii) claims which have been reported to the Company but not yet paid, each as of the financial statement date (collectively, "IBNR"). Health care costs payable also include an estimate of the cost of services that will continue to be rendered after the financial statement date if the Company is obligated to pay for such services in accordance with contractual or regulatory requirements. Such estimates are developed using actuarial principles and assumptions which consider, among other things, historical and projected claim submission and processing patterns, assumed and historical medical cost trends, historical utilization of medical services, claim inventory levels, changes in Insured membership and product mix, seasonality and other relevant factors. The Company reflects changes in these estimates in benefit costs in the Company's consolidated operating results in the period they are determined. Capitation costs represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the volume of medical services provided to the Insured member. Amounts due under risk-sharing arrangements are based on the terms of the underlying contracts with the providers and consider claims experience under the contracts through the financial statement date.

The Company develops its estimate of IBNR using actuarial principles and assumptions that consider numerous factors. Of those factors, the Company considers the analysis of historical and projected claim payment patterns (including claims submission and processing patterns) and the assumed health care cost trend rate (the year-over-year change in per member per month health care costs) to be the most critical assumptions. In developing its IBNR estimate, the Company consistently applies these actuarial principles and assumptions each period, with consideration to the variability of related factors. There have been no significant changes to the methodologies or assumptions used to develop the Company's estimate of IBNR in 2021.

The Company analyzes historical claim payment patterns by comparing claim incurred dates (i.e., the date services were provided) to claim payment dates to estimate "completion factors." The Company uses completion factors predominantly to estimate the ultimate cost of claims incurred more than three months before the financial statement date. The Company estimates completion factors by aggregating claim data based on the month of service and month of claim payment and estimating the percentage of claims incurred for a given month that are complete by each month thereafter. For any given month, substantially all claims are paid within six months of the date of service, but it can take up to 48 months or longer after the date of service before all of the claims are completely resolved and paid. These historically-derived completion factors are then applied to claims paid through the financial statement date to estimate the ultimate claim cost for a given month's incurred claim activity. The difference between the estimated ultimate claim cost and the claims paid through the financial statement date represents the Company's estimate of claims remaining to be paid as of the financial statement date and is included in the Company's health care costs payable. The completion factors the Company uses reflect judgments and possible adjustments based on data such as claim inventory levels, claim submission and processing patterns and, to a lesser extent, other factors such as changes in health care cost trend rates, changes in Insured membership and changes in product mix. If claims are submitted or processed on a faster (slower) pace than prior periods, the actual claims may be more (less) complete than originally estimated using the Company's completion factors, which may result in reserves that are higher (lower) than the ultimate cost of claims.

Because claims incurred within three months before the financial statement date are less mature, the Company uses a combination of historically-derived completion factors and the assumed health care cost trend rate to estimate the ultimate cost of claims incurred for these months. The Company applies its actuarial judgment and places a greater emphasis on the assumed health care cost trend rate for the most recent claim incurred dates as these months may be influenced by seasonal patterns and changes in membership and product mix.

The Company's health care cost trend rate is affected by changes in per member utilization of medical services as well as changes in the unit cost of such services. Many factors influence the health care cost trend rate, including the Company's ability to manage benefit costs through product design, negotiation of favorable provider contracts and medical management programs, as well as the mix of the Company's business. The health status of the Company's Insured members, aging of the population and other demographic characteristics, advances in medical technology and other factors continue to contribute to rising per member utilization and unit costs. Changes in health care practices, inflation, new technologies, increases in the cost of

prescription drugs (including specialty pharmacy drugs), direct-to-consumer marketing by pharmaceutical companies, clusters of high-cost cases, claim intensity, changes in the regulatory environment, health care provider or member fraud and numerous other factors also contribute to the cost of health care and the Company's health care cost trend rate.

For each reporting period, the Company uses an extensive degree of judgment in the process of estimating its health care costs payable. As a result, considerable variability and uncertainty is inherent in such estimates, particularly with respect to claims with claim incurred dates of three months or less before the financial statement date; and the adequacy of such estimates is highly sensitive to changes in assumed completion factors and the assumed health care cost trend rates. For each reporting period the Company recognizes the actuarial best estimate of health care costs payable considering the potential volatility in assumed completion factors and health care cost trend rates, as well as other factors. The Company believes its estimate of health care costs payable is reasonable and adequate to cover its obligations at December 31, 2021; however, actual claim payments may differ from the Company's estimates. A worsening (or improvement) of the Company's health care cost trend rates or changes in completion factors from those that the Company assumed in estimating health care costs payable at December 31, 2021 would cause these estimates to change in the near term, and such a change could be material.

Each quarter, the Company re-examines previously established health care costs payable estimates based on actual claim payments for prior periods and other changes in facts and circumstances. Given the extensive degree of judgment in this estimate, it is possible that the Company's estimates of health care costs payable could develop either favorably (that is, its actual benefit costs for the period were less than estimated) or unfavorably. The changes in the Company's estimate of health care costs payable may relate to a prior quarter, prior year or earlier periods. For a roll forward of the Company's health care costs payable, see Note 7 ‘‘Health Care Costs Payable.’’ The Company's reserving practice is to consistently recognize the actuarial best estimate of its ultimate liability for health care costs payable.

Other Insurance Liabilities

Unpaid Claims
Unpaid claims consist primarily of reserves associated with certain short-duration group disability and term life insurance contracts, including an estimate for IBNR as of the financial statement date. Reserves associated with certain short-duration group disability and term life insurance contracts are based upon the Company's estimate of the present value of future benefits, which is based on assumed investment yields and assumptions regarding mortality, morbidity and recoveries from the U.S. Social Security Administration. The Company develops its estimate of IBNR using actuarial principles and assumptions which consider, among other things, contractual requirements, claim incidence rates, claim recovery rates, seasonality and other relevant factors. The Company discounts certain claim liabilities related to group long-term disability and life insurance waiver of premium contracts. The discount rates generally reflect the Company's expected investment returns for the investments supporting all incurral years of these liabilities. The discount rates for retrospectively-rated contracts are set at contractually specified levels. The Company's estimates of unpaid claims are subject to change due to changes in the underlying experience of the insurance contracts, changes in investment yields or other factors, and these changes are recorded in current and future benefits in the consolidated statements of operations in the period they are determined. The Company estimates its reserve for claims IBNR for life products largely based on completion factors. The completion factors used are based on the Company's historical experience and reflect judgments and possible adjustments based on data such as claim inventory levels, claim payment patterns, changes in business volume and other factors. If claims are submitted or processed on a faster (slower) pace than historical periods, the actual claims may be more (less) complete than originally estimated using completion factors, which may result in reserves that are higher (lower) than required to cover future life benefit payments. There have been no significant changes to the methodologies or assumptions used to develop the Company's estimate of unpaid claims IBNR in 2021. As of December 31, 2021, unpaid claims balances of $324 million and $1.3 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively. As of December 31, 2020, unpaid claims balances of $532 million and $1.5 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively.

Substantially all life and disability insurance liabilities have been fully ceded to unrelated third parties through indemnity reinsurance agreements; however, the Company remains directly obligated to the policyholders.

Future Policy Benefits

Future policy benefits consist primarily of reserves for limited payment pension and annuity contracts and long-term care insurance contracts. Reserves for limited payment pension and annuity contracts are computed using actuarial principles that consider, among other things, assumptions reflecting anticipated mortality, retirement, expense and interest rate experience. Such assumptions generally vary by plan, year of issue and policy duration. Assumed interest rates on such contracts ranged from 3.0% to 11.3% in the year ended December 31, 2021 and from 3.3% to 11.3% in the year ended December 31, 2020. The Company periodically reviews mortality assumptions against both industry standards and its experience. Reserves for long-

duration long-term care contracts represent the Company's estimate of the present value of future benefits and essential maintenance expenses to be paid to or on behalf of policyholders less the present value of future gross premiums. The assumed interest rate on such contracts was 5.1% in both the years ended December 31, 2021 and 2020. The Company's estimate of the present value of future benefits under such contracts is based upon mortality, morbidity and interest rate assumptions. As of December 31, 2021, future policy benefits balances of $416 million and $5.1 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively. As of December 31, 2020, future policy benefits balances of $462 million and $5.5 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively.

Premium Deficiency Reserves

The Company evaluates its insurance contracts to determine if it is probable that a loss will be incurred. A premium deficiency loss is recognized when it is probable that expected future claims, including maintenance costs (for example, direct costs such as claim processing costs), will exceed existing reserves plus anticipated future premiums and reinsurance recoveries. Anticipated investment income is not considered in the calculation of premium deficiency losses for short-duration contracts. For purposes of determining premium deficiency losses, contracts are grouped consistent with the Company's method of acquiring, servicing and measuring the profitability of such contracts. As of December 31, 2021 and 2020, the Company established a premium deficiency reserve of $16 million and $11 million, respectively, related to Medicaid products in the Health Care Benefits segment.

Policyholders' Funds

Policyholders' funds consist primarily of reserves for pension and annuity investment contracts and customer funds associated with certain health contracts. Reserves for such contracts are equal to cumulative deposits less withdrawals and charges plus interest credited thereon, net of experience-rated adjustments. In 2021, interest rates for pension and annuity investment contracts ranged from 3.5% to 4.8%. In 2020, interest rates for pension and annuity investment contracts ranged from 4.1% to 5.1%. Reserves for contracts subject to experience rating reflect the Company's rights as well as the rights of policyholders and plan participants. The Company also holds funds for HSAs on behalf of members associated with high deductible health plans. These amounts are held to pay for qualified health care expenses incurred by these members. The HSA balances were approximately $2.9 billion and $2.7 billion at December 31, 2021 and 2020, respectively, and are reflected in other current assets with a corresponding liability in policyholders' funds. These assets are considered restricted cash for cash flow statement purposes.

Policyholders' funds liabilities that are expected to be paid within twelve months from the balance sheet date are classified as current on the consolidated balance sheets. Policyholders' funds liabilities that are expected to be paid greater than twelve months from the balance sheet date are included in other long-term liabilities on the consolidated balance sheets.

Self-Insurance Liabilities

The Company is self-insured for certain losses related to general liability, workers' compensation and auto liability. The Company obtains third party insurance coverage to limit exposure from these claims. The Company is also self-insured for certain losses related to health and medical liabilities. The Company's self-insurance accruals, which include reported claims and claims incurred but not reported, are calculated using standard insurance industry actuarial assumptions and the Company's historical claims experience. At December 31, 2021 and 2020, self-insurance liabilities totaled $1.1 billion and $927 million, respectively, and were recorded as accrued expenses on the consolidated balance sheets.

Foreign Currency Translation and Transactions

For non-U.S. dollar functional currency locations, (i) assets and liabilities are translated at end-of-period exchange rates, (ii) revenues and expenses are translated at average exchange rates in effect during the period and (iii) equity is translated at historical exchange rates. The resulting cumulative translation adjustments are included as a component of accumulated other comprehensive income.

For U.S. dollar functional currency locations, foreign currency assets and liabilities are remeasured into U.S. dollars at end-of-period exchange rates, except for nonmonetary balance sheet accounts which are remeasured at historical exchange rates. Revenues and expenses are remeasured at average exchange rates in effect during each period, except for those expenses related to the nonmonetary balance sheet amounts which are remeasured at historical exchange rates. Gains or losses from foreign currency remeasurement are included in net income.

Gains and losses from foreign currency transactions and the effects of foreign currency remeasurements were not material in the years ended December 31, 2021 or 2020. On July 1, 2019, the Company sold its Brazilian subsidiary, Drogaria Onofre Ltda. ("Onofre") for an immaterial amount. The Company recorded a loss on the divestiture, which included the elimination of the subsidiary's $154 million cumulative translation adjustment from accumulated other comprehensive income during the year ended December 31, 2019.

Revenue Recognition

Health Care Benefits Segment
Health Care Benefits revenue is principally derived from insurance premiums and fees billed to customers. Revenue is recognized based on customer billings, which, in the Company's Commercial business, reflect contracted rates per member and the number of covered members recorded in the Company's records at the time the billings are prepared. Billings are generally sent monthly for coverage during the following month. Revenue related to the Company's Government business is collected monthly from the U.S. federal government and various government agencies based on fixed payment rates and member eligibility.

The Company's billings may be subsequently adjusted to reflect enrollment changes due to member terminations or other factors. These adjustments are known as retroactivity adjustments. In each period, the Company estimates the amount of future retroactivity and adjusts the recorded revenue accordingly. As information regarding actual retroactivity amounts becomes known, the Company refines its estimates and records any required adjustments to revenues in the period in which they arise.

Premium Revenue
Premiums are recognized as revenue in the month in which the enrollee is entitled to receive health care services. Premiums are reported net of an allowance for estimated terminations and uncollectible amounts. Additionally, premium revenue subject to the minimum medical loss ratio ("MLR") rebate requirements of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (as amended, collectively, the "ACA") is recorded net of the estimated minimum MLR rebates for the current calendar year. Premiums related to unexpired contractual coverage periods (unearned premiums) are reported as other insurance liabilities on the consolidated balance sheets and recognized as revenue when earned.

Some of the Company's contracts allow for premiums to be adjusted to reflect actual experience or the relative health status of Insured members. Such adjustments are reasonably estimable at the outset of the contract, and adjustments to those estimates are made based on actual experience of the customer emerging under the contract and the terms of the underlying contract.

Services Revenue
Services revenue relates to contracts that can include various combinations of services or series of services which generally are capable of being distinct and accounted for as separate performance obligations. The Health Care Benefits segment's services revenue primarily consists of ASC fees received in exchange for performing certain claim processing and member services for ASC members. ASC fee revenue is recognized over the period the service is provided. Some of the Company's administrative services contracts include guarantees with respect to certain functions, such as customer service response time, claim processing accuracy and claim processing turnaround time, as well as certain guarantees that a plan sponsor's benefit claim experience will fall within a certain range. With any of these guarantees, the Company is financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk typically is limited to a percentage of the fees otherwise payable to the Company by the customer involved. Each period the Company estimates its obligations under the terms of these guarantees and records its estimate as an offset to services revenues.

Accounting for Medicare Part D
Revenues include insurance premiums earned by the Company's PDPs, which are determined based on the PDP's annual bid and related contractual arrangements with the U.S. Centers for Medicare & Medicaid Services ("CMS"). The insurance premiums include a beneficiary premium, which is the responsibility of the PDP member, and can be subsidized by CMS in the case of low-income members, and a direct premium paid by CMS. Premiums collected in advance are initially recorded within other insurance liabilities and are then recognized ratably as revenue over the period in which members are entitled to receive benefits.

Revenues also include a risk-sharing feature of the Medicare Part D program design referred to as the risk corridor. The Company estimates variable consideration in the form of amounts payable to, or receivable from, CMS under the risk corridor, and adjusts revenue based on calculations of additional subsidies to be received from or owed to CMS at the end of the reporting year.

In addition to Medicare Part D premiums, the Company receives additional payments each month from CMS related to catastrophic reinsurance, low-income cost-sharing subsidies and coverage gap benefits. If the subsidies received differ from the amounts earned from actual prescriptions transferred, the difference is recorded in either accounts receivable, net or accrued expenses.

Pharmacy Services Segment
The Pharmacy Services segment sells prescription drugs directly through its mail service dispensing pharmacies and indirectly through the Company's retail pharmacy network. The Company's pharmacy benefit arrangements are accounted for in a manner consistent with a master supply arrangement as there are no contractual minimum volumes and each prescription is considered a separate purchasing decision and distinct performance obligation transferred at a point in time. PBM services performed in connection with each prescription claim are considered part of a single performance obligation which culminates in the dispensing of prescription drugs.

The Company recognizes revenue using the gross method at the contract price negotiated with its clients when the Company has concluded it controls the prescription drug before it is transferred to the client plan members. The Company controls prescriptions dispensed indirectly through its retail pharmacy network because it has separate contractual arrangements with those pharmacies, has discretion in setting the price for the transaction and assumes primary responsibility for fulfilling the promise to provide prescription drugs to its client plan members while also performing the related PBM services.

Revenues include (i) the portion of the price the client pays directly to the Company, net of any discounts earned on brand name drugs or other discounts and refunds paid back to the client (see "Drug Discounts" and "Guarantees" below), (ii) the price paid to the Company by client plan members for mail order prescriptions and the price paid to retail network pharmacies by client plan members for retail prescriptions ("retail co-payments"), and (iii) claims based administrative fees for retail pharmacy network contracts. Sales taxes are not included in revenues.

The Company recognizes revenue when control of the prescription drugs is transferred to customers, in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those prescription drugs. The Company has established the following revenue recognition policies for the Pharmacy Services segment:

- Revenues generated from prescription drugs sold by mail service dispensing pharmacies are recognized when the prescription drug is delivered to the client plan member. At the time of delivery, the Company has performed substantially all of its performance obligations under its client contracts and does not experience a significant level of returns or reshipments.
- Revenues generated from prescription drugs sold by third party pharmacies in the Company's retail pharmacy network and associated administrative fees are recognized at the Company's point-of-sale, which is when the claim is adjudicated by the Company's online claims processing system and the Company has transferred control of the prescription drug and completed all of its performance obligations.

For contracts under which the Company acts as an agent or does not control the prescription drugs prior to transfer to the client plan member, revenue is recognized using the net method.

Drug Discounts
The Company records revenue net of manufacturers' rebates earned by its clients based on their plan members' utilization of brand-name formulary drugs. The Company estimates these rebates at period-end based on actual and estimated claims data and its estimates of the manufacturers' rebates earned by its clients. The estimates are based on the best available data at period-end and recent history for the various factors that can affect the amount of rebates due to the client. The Company adjusts its rebates payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. Any cumulative effect of these adjustments is recorded against revenues at the time it is identified. Adjustments generally result from contract changes with clients or manufacturers that have retroactive rebate adjustments, differences between the estimated and actual product mix subject to rebates, or whether the brand name drug was included in the applicable formulary. The effect of adjustments between estimated and actual manufacturers' rebate amounts has not been material to the Company's operating results or financial condition.

Guarantees

The Company also adjusts revenues for refunds owed to clients resulting from pricing guarantees and performance against defined service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Retail/LTC Segment

Retail Pharmacy

The Company's retail drugstores recognize revenue at the time the customer takes possession of the merchandise. For pharmacy sales, each prescription claim is its own arrangement with the customer and is a performance obligation, separate and distinct from other prescription claims under other retail network arrangements. Revenues are adjusted for refunds owed to third party payers resulting from pricing guarantees and performance against defined value-based service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Revenue from Company gift cards purchased by customers is deferred as a contract liability until goods or services are transferred. Any amounts not expected to be redeemed by customers (i.e., breakage) are recognized based on historical redemption patterns.

Customer returns are not material to the Company's operating results or financial condition. Sales taxes are not included in revenues.

Loyalty and Other Programs

The Company's customer loyalty program, ExtraCare®, consists of two components, ExtraSavings™ and ExtraBucks® Rewards. ExtraSavings are coupons that are recorded as a reduction of revenue when redeemed as the Company concluded that they do not represent a promise to the customer to deliver additional goods or services at the time of issuance because they are not tied to a specific transaction or spending level.

ExtraBucks Rewards are accumulated by customers based on their historical spending levels. Thus, the Company has determined that there is an additional performance obligation to those customers at the time of the initial transaction. The Company allocates the transaction price to the initial transaction and the ExtraBucks Rewards transaction based upon the relative standalone selling price, which considers historical redemption patterns for the rewards. Revenue allocated to ExtraBucks Rewards is recognized as those rewards are redeemed. At the end of each period, unredeemed ExtraBucks Rewards are reflected as a contract liability.

The Company also offers a subscription-based membership program, CarePass®, under which members are entitled to a suite of benefits delivered over the course of the subscription period, as well as a promotional reward that can be redeemed for future goods and services. Subscriptions are paid for on a monthly or annual basis at the time of or in advance of the Company delivering the goods and services. Revenue from these arrangements is recognized as the performance obligations are satisfied.

Long-term Care

Revenue is recognized when control of the promised goods or services is transferred to customers in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those goods or services. Each prescription claim represents a separate performance obligation of the Company, separate and distinct from other prescription claims under customer arrangements. A significant portion of long-term care revenue from sales of pharmaceutical and medical products is reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. The Company monitors its revenues and receivables from these reimbursement sources, as well as long-term care facilities and other third party insurance payors, and reduces revenue at the revenue recognition date to properly account for the variable consideration due to anticipated differences between billed and reimbursed amounts. Accordingly, the total revenues and receivables reported in the Company's consolidated financial statements are recorded at the amount expected to be ultimately received from these payors.

Patient co-payments associated with Medicare Part D, certain state Medicaid programs, Medicare Part B and certain third party payors typically are not collected at the time products are delivered or services are rendered, but are billed to the individuals as part of normal billing procedures and subject to normal accounts receivable collections procedures.

Walk-In Medical Clinics

For services provided by the Company’s walk-in medical clinics, revenue recognition occurs for completed services provided to patients, with adjustments taken for third party payor contractual obligations and patient direct bill historical collection rates.

Disaggregation of Revenue
The following table disaggregates the Company's revenue by major source in each segment for the years ended December 31, 2021, 2020 and 2019:

In millions	Health Care Benefits	Pharmacy Services	Retail/ LTC	Corporate/ Other	Intersegment Eliminations	Consolidated Totals
2021						
Major goods/services lines:						
Pharmacy	$ —	$ 152,262	$ 76,121	$ —	$ (43,765)	$ 184,618
Front Store	—	—	21,315	—	—	21,315
Premiums	76,064	—	—	68	—	76,132
Net investment income	586	—	17	596	—	1,199
Other	5,536	760	2,652	57	(158)	8,847
Total	$ 82,186	$ 153,022	$ 100,105	$ 721	$ (43,923)	$ 292,111
Pharmacy Services distribution channel:						
Pharmacy network [1]		$ 91,715				
Mail choice [2]		60,547				
Other		760				
Total		$ 153,022				
2020						
Major goods/services lines:						
Pharmacy	$ —	$ 141,116	$ 70,176	$ —	$ (40,003)	$ 171,289
Front Store	—	—	19,655	—	—	19,655
Premiums	69,301	—	—	63	—	69,364
Net investment income	483	—	—	315	—	798
Other	5,683	822	1,367	48	(320)	7,600
Total	$ 75,467	$ 141,938	$ 91,198	$ 426	$ (40,323)	$ 268,706
Pharmacy Services distribution channel:						
Pharmacy network [1]		$ 85,045				
Mail choice [2]		56,071				
Other		822				
Total		$ 141,938				
2019						
Major goods/services lines:						
Pharmacy	$ —	$ 140,896	$ 66,442	$ —	$ (41,413)	$ 165,925
Front Store	—	—	19,422	—	—	19,422
Premiums	63,031	—	—	91	—	63,122
Net investment income	599	—	—	412	—	1,011
Other	5,974	595	744	9	(26)	7,296
Total	$ 69,604	$ 141,491	$ 86,608	$ 512	$ (41,439)	$ 256,776
Pharmacy Services distribution channel:						
Pharmacy network [1]		$ 88,755				
Mail choice [2]		52,141				
Other		595				
Total		$ 141,491				

(1) Pharmacy Services pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including the Company's retail pharmacies and LTC pharmacies, but excluding Maintenance Choice® activity, which is included within the mail choice category. Maintenance Choice permits eligible client plan members to fill their maintenance prescriptions through mail order delivery or at a CVS Pharmacy retail store for the same price as mail order.

(2) Pharmacy Services mail choice is defined as claims filled at a Pharmacy Services mail order facility, which includes specialty mail claims inclusive of Specialty Connect® claims picked up at a retail pharmacy, as well as prescriptions filled at the Company's retail pharmacies under the Maintenance Choice program.

Contract Balances

Contract liabilities primarily represent the Company's obligation to transfer additional goods or services to a customer for which the Company has received consideration, and include ExtraBucks Rewards and unredeemed Company gift cards. The consideration received remains a contract liability until goods or services have been provided to the customer. In addition, the Company recognizes breakage on Company gift cards based on historical redemption patterns.

The following table provides information about receivables and contract liabilities from contracts with customers as of December 31, 2021 and 2020:

In millions	**2021**	**2020**
Trade receivables (included in accounts receivable, net)	$ 7,932	$ 7,101
Contract liabilities (included in accrued expenses)	87	71

During the years ended December 31, 2021 and 2020, the contract liabilities balance includes increases related to customers' earnings in ExtraBucks Rewards or issuances of Company gift cards and decreases for revenues recognized during the period as a result of the redemption of ExtraBucks Rewards or Company gift cards and breakage of Company gift cards. Below is a summary of such changes:

In millions	**2021**	**2020**
Contract liabilities, beginning of period	$ 71	$ 73
Rewards earnings and gift card issuances	387	357
Redemption and breakage	(371)	(359)
Contract liabilities, end of period	$ 87	$ 71

Cost of Products Sold

The Company accounts for cost of products sold as follows:

Pharmacy Services Segment

Cost of products sold includes: (i) the cost of prescription drugs sold during the reporting period directly through the Company's mail service dispensing pharmacies and indirectly through the Company's retail pharmacy network, (ii) shipping and handling costs, and (iii) the operating costs of the Company's mail service dispensing pharmacies and client service operations and related information technology support costs including depreciation and amortization. The cost of prescription drugs sold component of cost of products sold includes: (i) the cost of the prescription drugs purchased from manufacturers or distributors and shipped to members in clients' benefit plans from the Company's mail service dispensing pharmacies, net of any volume-related or other discounts (see "Vendor Allowances and Purchase Discounts" below) and (ii) the cost of prescription drugs sold (including retail co-payments) through the Company's retail pharmacy network under contracts where the Company is the principal, net of any volume-related or other discounts.

Retail/LTC Segment

Cost of products sold includes: the cost of merchandise sold during the reporting period, including prescription drug costs, and the related purchasing costs, warehousing and delivery costs (including depreciation and amortization) and actual and estimated inventory losses.

Vendor Allowances and Purchase Discounts

The Company accounts for vendor allowances and purchase discounts as follows:

Pharmacy Services Segment
The Pharmacy Services segment receives purchase discounts on products purchased. Contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for the Pharmacy Services segment to receive

purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These rebates are recognized when prescriptions are dispensed and are generally calculated and billed to manufacturers within 30 days of the end of each completed quarter. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material to the Company's operating results or financial condition. The Company accounts for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. The Pharmacy Services segment also receives additional discounts under its wholesaler contracts if it exceeds contractually defined purchase volumes. In addition, the Pharmacy Services segment receives fees from pharmaceutical manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of cost of products sold.

Retail/LTC Segment
Vendor allowances received by the Retail/LTC segment reduce the carrying cost of inventory and are recognized in cost of products sold when the related inventory is sold, unless they are specifically identified as a reimbursement of incremental costs for promotional programs and/or other services provided. Amounts that are directly linked to advertising commitments are recognized as a reduction of advertising expense (included in operating expenses) when the related advertising commitment is satisfied. Any amounts received in excess of the actual cost incurred also reduce the carrying cost of inventory. The total value of any upfront payments received from vendors that are linked to purchase commitments is initially deferred. The deferred amounts are then amortized to reduce cost of products sold over the life of the contract based upon sales volume. The total value of any upfront payments received from vendors that are not linked to purchase commitments is also initially deferred. The deferred amounts are then amortized to reduce cost of products sold on a straight-line basis over the life of the related contract. The total amortization of these upfront payments was not material to the Company's consolidated financial statements in any of the periods presented.

Health Care Reform

Health Insurer Fee
Since January 1, 2014, the ACA has imposed an annual premium-based health insurer fee ("HIF") for each calendar year, payable in September, which was not deductible for tax purposes. The Company has been required to estimate a liability for the HIF at the beginning of the calendar year in which the fee was payable with a corresponding deferred asset that was amortized ratably to operating expenses over the calendar year. The Company recorded the liability for the HIF in accrued expenses and recorded the deferred asset in other current assets. In December 2019, the HIF was repealed for calendar years after 2020, therefore there was no expense related to the HIF in the year ended December 31, 2021. In the year ended December 31, 2020, operating expenses included $1.0 billion related to the Company's share of the HIF. There was no expense related to the HIF in 2019, since there was a one-year suspension of the HIF for 2019.

Risk Adjustment
The ACA established a permanent risk adjustment program to transfer funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of the Company's qualified plan members relative to the average risk of members of other qualified plans in comparable markets, as defined by the ACA, the Company estimates its ultimate risk adjustment receivable (recorded in accounts receivable) or payable (recorded in accrued expenses) for the current calendar year and reflects the pro-rata year-to-date impact as an adjustment to premium revenue.

Risk Corridor
The ACA established a temporary risk corridor program, which expired at the end of 2016, for qualified individual and small group health insurance plans. Under this program, health insurance companies were to make payments to, or receive payments from, the U.S. Department of Health and Human Services ("HHS") based on their ratio of allowable costs to target costs (as defined by the ACA).

The Company filed a lawsuit in August 2019 to recover the $313 million it was owed under the ACA's risk corridor program, which had been stayed pending the Supreme Court decision. In April 2020, the U.S. Supreme Court ruled that health insurance companies may sue the federal government for amounts owed as calculated under the ACA's temporary risk corridor program.

In October 2020, the Company received the $313 million it was owed under the ACA's risk corridor program. The Company recorded the risk corridor payment as an increase to premium revenue in the year ended December 31, 2020. After considering

offsetting items such as the ACA's minimum MLR rebate requirements and premium taxes, the Company recorded pre-tax income of $307 million and after-tax income of $223 million during the year ended December 31, 2020.

Advertising Costs

Advertising costs, which are reduced by the portion funded by vendors, are expensed when the related advertising takes place. Net advertising costs, which are included in operating expenses, were $523 million, $461 million and $396 million in 2021, 2020 and 2019, respectively.

Stock-Based Compensation

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as expense over the requisite service period of the stock award (generally three to five years) using the straight-line method.

Income Taxes

The Company accounts for income taxes under the asset and liability method, which requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of events that have been included in the consolidated financial statements. Under this method, deferred tax assets and liabilities are determined on the basis of the differences between the consolidated financial statements and tax basis of assets and liabilities using enacted tax rates in effect for the year or years in which the differences are expected to reverse. The effect of a change in the tax rates on deferred tax assets and liabilities is recognized in income in the period that includes the enactment date of such change.

The Company recognizes deferred tax assets to the extent that it believes these assets are more likely than not to be realized. In making such a determination, the Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax planning strategies, and the Company's recent operating results. The Company establishes a valuation allowance when it does not consider it more likely than not that a deferred tax asset will be recovered.

The Company records uncertain tax positions on the basis of a two-step process whereby (1) the Company determines whether it is more likely than not that the tax positions will be sustained on the basis of the technical merits of the position and (2) for those tax positions that meet the more-likely-than-not recognition threshold, the Company recognizes the largest amount of tax benefit that is more than 50% likely to be realized upon ultimate settlement with the related tax authority.

Interest and/or penalties related to uncertain tax positions are recognized in the income tax provision.

Measurement of Defined Benefit Pension and Other Postretirement Employee Benefit Plans

The Company sponsors defined benefit pension plans ("pension plans") and other postretirement employee benefit plans ("OPEB plans") for its employees and retirees. The Company recognizes the funded status of its pension and OPEB plans on the consolidated balance sheets based on the year-end measurements of plan assets and benefit obligations. When the fair value of plan assets are in excess of the plan benefit obligations, the amounts are reported in other current assets and other assets. When the fair value of plan benefit obligations are in excess of plan assets, the amounts are reported in accrued expenses and other long-term liabilities based on the amount by which the actuarial present value of benefits payable in the next twelve months included in the benefit obligation exceeds the fair value of plan assets. The net periodic benefit cost (income) for the Company's pension and OPEB plans do not contain a service cost component as these plans have been frozen for an extended period of time. Non-service cost components of pension and postretirement net periodic benefit cost (income) are included in other income in the consolidated statements of operations.

Earnings per Share

Earnings per share is computed using the two-class method. The Company calculates basic earnings per share based on the weighted average number of common shares outstanding for the period. See Note 14 ''Earnings Per Share'' for additional information.

Shares Held in Trust

The Company maintains grantor trusts, which held approximately one million shares of its common stock at both December 31, 2021 and 2020. These shares are designated for use under various employee compensation plans. Since the Company holds these shares, they are excluded from the computation of basic and diluted shares outstanding.

Variable Interest Entities

The Company has investments in (i) a generic pharmaceutical sourcing entity, (ii) certain hedge fund and private equity investments and (iii) certain real estate partnerships that are considered VIEs. The Company does not have a future obligation to fund losses or debts on behalf of these investments; however, it may voluntarily contribute funds. In evaluating whether the Company is the primary beneficiary of a VIE, the Company considers several factors, including whether the Company has (a) the power to direct the activities that most significantly impact the VIE's economic performance and (b) the obligation to absorb losses and the right to receive benefits that could potentially be significant to the VIE.

Variable Interest Entities - Primary Beneficiary
In 2014, the Company and Cardinal Health, Inc. ("Cardinal") established Red Oak Sourcing, LLC ("Red Oak"), a generic pharmaceutical sourcing entity in which the Company and Cardinal each own 50%. The Red Oak arrangement had an initial term of ten years. In 2021, the Red Oak arrangement was amended to extend the initial term an additional five years, for a total term of 15 years. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak; however, Red Oak does not own or hold inventory on behalf of either company. No physical assets (e.g., property and equipment) were contributed to Red Oak by either company, and minimal funding was provided to capitalize Red Oak. The Company has determined that it is the primary beneficiary of this VIE because it has the ability to direct the activities of Red Oak. Consequently, the Company consolidates Red Oak in its consolidated financial statements within the Retail/LTC segment.

Cardinal is required to pay the Company quarterly payments, which began in October 2014 and will extend through June 2029. As milestones are met, the quarterly payments increase. The Company received $183 million from Cardinal during each of the years ended December 31, 2021, 2020 and 2019. The payments reduce the Company's carrying value of inventory and are recognized in cost of products sold when the related inventory is sold. Amounts reimbursed by Cardinal for the years ended December 31, 2021, 2020 and 2019, and amounts due to or due from Cardinal at December 31, 2021 and 2020 were immaterial.

Variable Interest Entities - Other Variable Interest Holder
The Company has invested in certain VIEs for which it has determined that it is not the primary beneficiary, consisting of the following:

- *Hedge fund and private equity investments* - The Company invests in hedge fund and private equity investments in order to generate investment returns for its investment portfolio supporting its insurance businesses.
- *Real estate partnerships* - The Company invests in various real estate partnerships, including those that construct, own and manage low-income housing developments. For the low income housing development investments, substantially all of the projected benefits to the Company are from tax credits and other tax benefits.

The Company is not the primary beneficiary of these VIEs because the nature of the Company's involvement with the activities of these VIEs does not give the Company the power to direct the activities that most significantly impact their economic performance. The Company records the amount of its investment in these VIEs as long-term investments on the consolidated balance sheets and recognizes its share of each VIE's income or losses in net income (loss). The Company's maximum exposure to loss from these VIEs is limited to its investment balances as disclosed below and the risk of recapture of previously recognized tax credits related to the real estate partnerships, which the Company does not consider significant.

The total amount of other variable interest holder VIE assets included in long-term investments on the consolidated balance sheets at December 31, 2021 and 2020 was as follows:

In millions	**2021**	**2020**
Hedge fund investments	$ 463	$ 342
Private equity investments	601	547
Real estate partnerships	225	200
Total	$ 1,289	$ 1,089

Related Party Transactions

The Company has an equity method investment in SureScripts, LLC ("SureScripts"), which operates a clinical health information network. The Company utilizes this clinical health information network in providing services to its client plan members and retail customers. The Company expensed fees for the use of this network of $52 million, $56 million and $32 million in the years ended December 31, 2021, 2020 and 2019, respectively. The Company's investment in and equity in the earnings of SureScripts for all periods presented is immaterial.

The Company has an equity method investment in Heartland Healthcare Services, LLC ("Heartland"). Heartland operates several LTC pharmacies in four states. Heartland paid the Company $79 million, $77 million and $96 million for pharmaceutical inventory purchases during the years ended December 31, 2021, 2020 and 2019, respectively. Additionally, the Company performs certain collection functions for Heartland and then transfers those customer cash collections to Heartland. The Company's investment in and equity in the earnings of Heartland for all periods presented is immaterial.

During the years ended December 31, 2021, 2020 and 2019, the Company made charitable contributions of $50 million, $50 million and $30 million, respectively, to the CVS Health Foundation, a non-profit entity that focuses on health, education and community involvement programs. The charitable contributions were recorded as operating expenses in the consolidated statements of operations within the Corporate/Other segment for the years ended December 31, 2021, 2020 and 2019.

Discontinued Operations

In connection with certain business dispositions completed between 1995 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Linens 'n Things and Bob's Stores, each of which subsequently filed for bankruptcy. The Company's loss from discontinued operations includes lease-related costs that the Company believes it will likely be required to satisfy pursuant to these lease guarantees. See "Lease Guarantees" in Note 16 ''Commitments and Contingencies'' for additional information.

Below is a summary of the results of discontinued operations for the year ended December 31, 2020.

In millions	**2020**
Loss from discontinued operations	$ (12)
Income tax benefit	3
Loss from discontinued operations, net of tax	$ (9)

Results from discontinued operations were immaterial for the years ended December 31, 2021 and 2019.

New Accounting Pronouncements Recently Adopted

Simplifying the Accounting for Income Taxes
In December 2019, the Financial Accounting Standards Board ("FASB") issued ASU 2019-12, *Simplifying the Accounting for Income Taxes* (Topic 740). This standard simplifies the accounting for income taxes by eliminating certain exceptions to the guidance in Accounting Standards Codification 740 related to the approach for intraperiod tax allocation, the methodology for calculating income taxes in an interim period and the recognition of deferred tax liabilities for outside basis differences. The standard also simplifies aspects of the accounting for franchise taxes and enacted changes in tax laws or rates and clarifies the accounting for transactions that result in a step-up in the tax basis of goodwill. The Company adopted this new accounting standard on January 1, 2021. The adoption of this standard did not have a material impact on the Company's consolidated operating results, cash flows, financial condition or related disclosures.

New Accounting Pronouncements Not Yet Adopted

Targeted Improvements to the Accounting for Long-Duration Insurance Contracts
In August 2018, the FASB issued ASU 2018-12, *Targeted Improvements to the Accounting for Long-Duration Contracts* (Topic 944). This standard requires the Company to review cash flow assumptions for its long-duration

insurance contracts at least annually and recognize the effect of changes in future cash flow assumptions in net income. This standard also requires the Company to update discount rate assumptions quarterly and recognize the effect of changes in these assumptions in other comprehensive income. The rate used to discount the Company's liability for future policy benefits will be based on an estimate of the yield for an upper-medium grade fixed-income instrument with a duration profile matching that of the Company's

liabilities. In addition, this standard changes the amortization method for deferred acquisition costs and requires additional disclosures regarding the long duration insurance contract liabilities in the Company's interim and annual financial statements. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2022. The Company will adopt the new standard on January 1, 2023, using the modified retrospective transition method as of the earliest period presented for changes to the liability for future policy benefits and deferred acquisition costs. While the Company is still evaluating the impact of the new standard on its financial statements, the Company anticipates an increase to its liability for future policy benefits with a corresponding change in accumulated other comprehensive income as a result of updating the rate used to discount the liabilities to reflect the yield for an upper-medium grade fixed-income instrument compared to the Company's expected investment yield under the existing guidance.

2. Divestitures

Divestiture of Workers' Compensation Business

On July 31, 2020, the Company sold its Workers' Compensation business for approximately $850 million. The results of this business were reported within the Health Care Benefits segment. The Company recorded a pre-tax gain on the divestiture of $269 million in the year ended December 31, 2020, which is reflected as a reduction in operating expenses in the Company's consolidated statement of operations within the Health Care Benefits segment.

Divestiture of Brazilian Subsidiary

On July 1, 2019, the Company sold its Brazilian subsidiary, Onofre, for an immaterial amount. Onofre operated 50 retail pharmacy stores, the results of which historically had been reported within the Retail/LTC segment. The Company recorded a pre-tax loss on the divestiture of $205 million in the year ended December 31, 2019, which primarily relates to the elimination of the cumulative translation adjustment from accumulated other comprehensive income and is reflected in operating expenses in the Company's consolidated statement of operations within the Retail/LTC segment.

3. Investments

Total investments at December 31, 2021 and 2020 were as follows:

	2021			2020		
In millions	**Current**	**Long-term**	**Total**	**Current**	**Long-term**	**Total**
Debt securities available for sale	$ 3,009	$ 20,231	$ 23,240	$ 2,774	$ 18,414	$ 21,188
Mortgage loans	58	844	902	226	821	1,047
Other investments	50	1,950	2,000	—	1,577	1,577
Total investments	$ 3,117	$ 23,025	$ 26,142	$ 3,000	$ 20,812	$ 23,812

At December 31, 2021 and 2020, the Company held investments of $450 million and $524 million, respectively, related to the 2012 conversion of an existing group annuity contract from a participating to a non-participating contract. These investments are included in the total investments of large case pensions supporting non-experience-rated products. Although these investments are not accounted for as Separate Accounts assets, they are legally segregated and are not subject to claims that arise out of the Company's business and only support future policy benefits obligations under that group annuity contract.

Debt Securities

Debt securities available for sale at December 31, 2021 and 2020 were as follows:

In millions	Amortized Cost [1]	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2021				
Debt securities:				
U.S. government securities	$ 2,349	$ 70	$ (3)	$ 2,416
States, municipalities and political subdivisions	2,947	148	(4)	3,091
U.S. corporate securities	9,093	682	(40)	9,735
Foreign securities	2,821	196	(24)	2,993
Residential mortgage-backed securities	870	15	(10)	875
Commercial mortgage-backed securities	1,278	44	(12)	1,310
Other asset-backed securities	2,791	14	(13)	2,792
Redeemable preferred securities	25	3	—	28
Total debt securities [2]	$ 22,174	$ 1,172	$ (106)	$ 23,240
December 31, 2020				
Debt securities:				
U.S. government securities	$ 2,341	$ 128	$ —	$ 2,469
States, municipalities and political subdivisions	2,556	172	—	2,728
U.S. corporate securities	7,879	1,023	(8)	8,894
Foreign securities	2,595	324	(1)	2,918
Residential mortgage-backed securities	673	32	—	705
Commercial mortgage-backed securities	962	84	—	1,046
Other asset-backed securities	2,369	36	(2)	2,403
Redeemable preferred securities	21	4	—	25
Total debt securities [2]	$ 19,396	$ 1,803	$ (11)	$ 21,188

(1) There was no allowance for expected credit losses recorded on available-for-sale debt securities at December 31, 2021 or 2020.

(2) Investment risks associated with the Company's experience-rated products generally do not impact the Company's consolidated operating results. At December 31, 2021, debt securities with a fair value of $864 million, gross unrealized capital gains of $94 million and gross unrealized capital losses of $2 million and at December 31, 2020, debt securities with a fair value of $919 million, gross unrealized capital gains of $135 million and no gross unrealized capital losses were included in total debt securities, but support experience-rated products. Changes in net unrealized capital gains (losses) on these securities are not reflected in accumulated other comprehensive income.

The amortized cost and fair value of debt securities at December 31, 2021 are shown below by contractual maturity. Actual maturities may differ from contractual maturities because securities may be restructured, called or prepaid, or the Company intends to sell a security prior to maturity.

In millions	**Amortized Cost**	**Fair Value**
Due to mature:		
Less than one year	$ 1,205	$ 1,218
One year through five years	6,965	7,142
After five years through ten years	4,733	4,910
Greater than ten years	4,332	4,993
Residential mortgage-backed securities	870	875
Commercial mortgage-backed securities	1,278	1,310
Other asset-backed securities	2,791	2,792
Total	$ 22,174	$ 23,240

Mortgage-Backed and Other Asset-Backed Securities
All of the Company's residential mortgage-backed securities at December 31, 2021 were issued by the Government National Mortgage Association, the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation and carry agency guarantees and explicit or implicit guarantees by the U.S. Government. At December 31, 2021, the Company's residential mortgage-backed securities had an average credit quality rating of AAA and a weighted average duration of 4.7 years.

The Company's commercial mortgage-backed securities have underlying loans that are dispersed throughout the United States. Significant market observable inputs used to value these securities include loss severity and probability of default. At December 31, 2021, these securities had an average credit quality rating of AAA and a weighted average duration of 6.1 years.

The Company's other asset-backed securities have a variety of underlying collateral (e.g., automobile loans, credit card receivables, home equity loans and commercial loans). Significant market observable inputs used to value these securities include the unemployment rate, loss severity and probability of default. At December 31, 2021, these securities had an average credit quality rating of AA and a weighted average duration of 1.0 year.

Summarized below are the debt securities the Company held at December 31, 2021 and 2020 that were in an unrealized capital loss position, aggregated by the length of time the investments have been in that position:

	Less than 12 months			Greater than 12 months			Total		
In millions, except number of securities	**Number of Securities**	**Fair Value**	**Unrealized Losses**	**Number of Securities**	**Fair Value**	**Unrealized Losses**	**Number of Securities**	**Fair Value**	**Unrealized Losses**
December 31, 2021									
Debt securities:									
U.S. government securities	43	$ 242	$ 2	10	$ 40	$ 1	53	$ 282	$ 3
States, municipalities and political subdivisions	233	428	3	13	33	1	246	461	4
U.S. corporate securities	1,610	2,296	31	165	238	9	1,775	2,534	40
Foreign securities	449	747	20	57	91	4	506	838	24
Residential mortgage-backed securities	165	593	9	10	36	1	175	629	10
Commercial mortgage-backed securities	188	462	7	35	112	5	223	574	12
Other asset-backed securities	1,011	2,030	12	26	31	1	1,037	2,061	13
Redeemable preferred securities	1	2	—	1	3	—	2	5	—
Total debt securities	3,700	$ 6,800	$ 84	317	$ 584	$ 22	4,017	$ 7,384	$ 106
December 31, 2020									
Debt securities:									
U.S. government securities	32	$ 205	$ —	—	$ —	$ —	32	$ 205	$ —
States, municipalities and political subdivisions	49	83	—	—	—	—	49	83	—
U.S. corporate securities	145	155	8	2	—	—	147	155	8
Foreign securities	41	69	1	5	5	—	46	74	1
Residential mortgage-backed securities	23	26	—	3	—	—	26	26	—
Commercial mortgage-backed securities	22	75	—	—	—	—	22	75	—
Other asset-backed securities	156	256	1	49	41	1	205	297	2
Total debt securities	468	$ 869	$ 10	59	$ 46	$ 1	527	$ 915	$ 11

The Company reviewed the securities in the table above and concluded that they are performing assets generating investment income to support the needs of the Company's business. In performing this review, the Company considered factors such as the quality of the investment security based on research performed by the Company's internal credit analysts and external rating agencies and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. Unrealized capital losses at December 31, 2021 were generally caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities. As of December 31, 2021, the Company did not intend to sell these securities, and did not believe it was more likely than not that it would be required to sell these securities prior to the anticipated recovery of their amortized cost basis.

The maturity dates for debt securities in an unrealized capital loss position at December 31, 2021 were as follows:

	Supporting experience-rated products		Supporting remaining products		Total	
In millions	**Fair Value**	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**
Due to mature:						
Less than one year	$ 2	$ —	$ 49	$ 1	$ 51	$ 1
One year through five years	13	1	2,229	32	2,242	33
After five years through ten years	33	1	1,332	26	1,365	27
Greater than ten years	17	—	445	10	462	10
Residential mortgage-backed securities	4	—	625	10	629	10
Commercial mortgage-backed securities	6	—	568	12	574	12
Other asset-backed securities	4	—	2,057	13	2,061	13
Total	$ 79	$ 2	$ 7,305	$ 104	$ 7,384	$ 106

Mortgage Loans

The Company's mortgage loans are collateralized by commercial real estate. During the years ended December 31, 2021 and 2020, the Company had the following activity in its mortgage loan portfolio:

In millions	**2021**	**2020**
New mortgage loans	$ 262	$ 63
Mortgage loans fully repaid	373	187
Mortgage loans foreclosed	—	—

The Company assesses mortgage loans on a regular basis for credit impairments, and assigns a credit quality indicator to each loan. The Company's credit quality indicator is internally developed and categorizes each loan in its portfolio on a scale from 1 to 7. These indicators are based upon several factors, including current loan-to-value ratios, current and future property cash flow, property condition, market trends, creditworthiness of the borrower and deal structure.

- *Category 1* - Represents loans of superior quality.
- *Categories 2 to 4* - Represent loans where credit risk is minimal to acceptable; however, these loans may display some susceptibility to economic changes.
- *Categories 5 and 6* - Represent loans where credit risk is not substantial, but these loans warrant management's close attention.
- *Category 7* - Represents loans where collections are potentially at risk; if necessary, an impairment is recorded.

Based upon the Company's assessments at December 31, 2021 and 2020, the amortized cost basis of the Company's mortgage loans within each credit quality indicator by year of origination was as follows:

	Amortized Cost Basis by Year of Origination						
In millions, except credit quality indicator	**2021**	**2020**	**2019**	**2018**	**2017**	**Prior**	**Total**
December 31, 2021							
1	$ —	$ —	$ —	$ —	$ —	$ 28	$ 28
2 to 4	255	48	40	72	97	349	861
5 and 6	—	—	—	3	4	6	13
7	—	—	—	—	—	—	—
Total	$ 255	$ 48	$ 40	$ 75	$ 101	$ 383	$ 902
December 31, 2020							
1		$ —	$ —	$ —	$ 22	$ 37	$ 59
2 to 4		46	96	91	124	595	952
5 and 6		—	—	3	4	29	36
7		—	—	—	—	—	—
Total		$ 46	$ 96	$ 94	$ 150	$ 661	$ 1,047

At December 31, 2021 scheduled mortgage loan principal repayments were as follows:

In millions	
2022	$ 58
2023	100
2024	210
2025	76
2026	177
Thereafter	281
Total	$ 902

Net Investment Income

Sources of net investment income for the years ended December 31, 2021, 2020 and 2019 were as follows:

In millions	**2021**	**2020**	**2019**
Debt securities	$ 634	$ 598	$ 589
Mortgage loans	55	60	71
Other investments	381	123	194
Gross investment income	1,070	781	854
Investment expenses	(47)	(35)	(42)
Net investment income (excluding net realized capital gains or losses)	1,023	746	812
Net realized capital gains [(1)]	176	52	199
Net investment income [(2)]	$ 1,199	$ 798	$ 1,011

(1) Net realized capital gains are net of yield-related impairment losses on debt securities of $42 million and $49 million for the years ended December 31, 2021 and 2020, respectively. There were no credit-related losses on debt securities in the years ended December 31, 2021 and 2020. Net realized capital gains are net of other-than-temporary impairment ("OTTI") losses on debt securities of $24 million for the year ended December 31, 2019.

(2) Net investment income includes $38 million, $42 million and $44 million for the years ended December 31, 2021, 2020 and 2019, respectively, related to investments supporting experience-rated products.

Capital gains and losses recognized during the year ended December 31, 2021 related to investments in equity securities held as of December 31, 2021 were not material.

Excluding amounts related to experience-rated products, proceeds from the sale of available-for-sale debt securities and the related gross realized capital gains and losses in the years ended December 31, 2021, 2020 and 2019 were as follows:

In millions	**2021**	**2020**	**2019**
Proceeds from sales	$ 3,572	$ 3,913	$ 4,773
Gross realized capital gains	72	80	146
Gross realized capital losses	14	62	17

4. Fair Value

The preparation of the Company's consolidated financial statements in accordance with GAAP requires certain assets and liabilities to be reflected at their fair value and others to be reflected on another basis, such as an adjusted historical cost basis. In this note, the Company provides details on the fair value of financial assets and liabilities and how it determines those fair values. The Company presents this information for those financial instruments that are measured at fair value for which the change in fair value impacts net income attributable to CVS Health or other comprehensive income separately from other financial assets and liabilities.

Financial Instruments Measured at Fair Value on the Consolidated Balance Sheets

Certain of the Company's financial instruments are measured at fair value on the consolidated balance sheets. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by GAAP. The following are the levels of the hierarchy and a brief description of the type of valuation information ("valuation inputs") that qualifies a financial asset or liability for each level:

- Level 1 – Unadjusted quoted prices for identical assets or liabilities in active markets.
- Level 2 – Valuation inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, valuation inputs that are observable that are not prices (such as interest rates and credit risks) and valuation inputs that are derived from or corroborated by observable markets.
- Level 3 – Developed from unobservable data, reflecting the Company's assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, the Company uses these quoted market prices to determine the fair value of financial assets and liabilities and classifies these assets and liabilities in Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, the Company estimates fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities are classified in Level 2. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The following is a description of the valuation methodologies used for the Company's financial assets and liabilities that are measured at fair value, including the general classification of such assets and liabilities pursuant to the valuation hierarchy.

Cash and Cash Equivalents – The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. When quoted prices are available in an active market, cash equivalents are classified in Level 1 of the fair value hierarchy. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt Securities – Where quoted prices are available in an active market, debt securities are classified in Level 1 of the fair value hierarchy. The Company's Level 1 debt securities consist primarily of U.S. Treasury securities.

The fair values of the Company's Level 2 debt securities are obtained using models, such as matrix pricing, which use quoted market prices of debt securities with similar characteristics or discounted cash flows to estimate fair value. The

Company reviews these prices to ensure they are based on observable market inputs that include quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets and inputs that are observable that are not prices (such as interest rates and credit risks). The Company also reviews the methodologies and the assumptions used to calculate prices from these observable inputs. On a quarterly basis, the Company selects a sample of its Level 2 debt securities' prices and compares them to prices provided by a secondary source. Variances over a specified threshold are identified and reviewed to confirm the price provided by the primary source represents an appropriate estimate of fair value. In addition, the Company's internal investment team consistently compares the prices obtained for select Level 2 debt securities to the team's own independent estimates of fair value for those securities. The Company obtained one price for each of its Level 2 debt securities and did not adjust any of those prices at December 31, 2021 or 2020.

The Company also values certain debt securities using Level 3 inputs. For Level 3 debt securities, fair values are determined by outside brokers or, in the case of certain private placement securities, are priced internally. Outside brokers determine the value of these debt securities through a combination of their knowledge of the current pricing environment and market flows. The Company did not have any broker quoted debt securities for the years ended December 31, 2021 and 2020. For some private placement securities, the Company's internal staff determines the value of these debt securities by analyzing spreads of corporate and sector indices as well as interest spreads of comparable public bonds. Examples of these private placement Level 3 debt securities include certain U.S. and foreign securities and certain tax-exempt municipal securities.

Equity Securities – The Company currently has two classifications of equity securities: those that are publicly traded and those that are privately placed. Publicly-traded equity securities are classified in Level 1 because quoted prices are available for these securities in an active market. For privately placed equity securities, there is no active market; therefore, these securities are classified in Level 3 because the Company prices these securities through an internal analysis of each investment's financial statements and cash flow projections. Significant unobservable inputs consist of earnings and revenue multiples, discount for lack of marketability and comparability adjustments. An increase or decrease in any of these unobservable inputs would have resulted in a change in the fair value measurement.

There were no financial liabilities measured at fair value on a recurring basis on the consolidated balance sheets at December 31, 2021 or 2020. Financial assets measured at fair value on a recurring basis on the consolidated balance sheets at December 31, 2021 and 2020 were as follows:

In millions	**Level 1**	**Level 2**	**Level 3**	**Total**
December 31, 2021				
Cash and cash equivalents	$ 4,954	$ 4,454	$ —	$ 9,408
Debt securities:				
U.S. government securities	2,372	44	—	2,416
States, municipalities and political subdivisions	—	3,086	5	3,091
U.S. corporate securities	—	9,697	38	9,735
Foreign securities	—	2,983	10	2,993
Residential mortgage-backed securities	—	875	—	875
Commercial mortgage-backed securities	—	1,310	—	1,310
Other asset-backed securities	—	2,789	3	2,792
Redeemable preferred securities	—	28	—	28
Total debt securities	2,372	20,812	56	23,240
Equity securities	114	—	55	169
Total	$ 7,440	$ 25,266	$ 111	$ 32,817
December 31, 2020				
Cash and cash equivalents	$ 3,985	$ 3,869	$ —	$ 7,854
Debt securities:				
U.S. government securities	2,370	99	—	2,469
States, municipalities and political subdivisions	—	2,727	1	2,728
U.S. corporate securities	—	8,842	52	8,894
Foreign securities	—	2,918	—	2,918
Residential mortgage-backed securities	—	705	—	705
Commercial mortgage-backed securities	—	1,046	—	1,046
Other asset-backed securities	—	2,403	—	2,403
Redeemable preferred securities	—	24	1	25
Total debt securities	2,370	18,764	54	21,188
Equity securities	17	—	30	47
Total	$ 6,372	$ 22,633	$ 84	$ 29,089

The changes in the balances of Level 3 financial assets during the year ended December 31, 2021 were as follows:

In millions	States, municipalities and political subdivisions	U.S. corporate securities	Foreign securities	Other asset-backed securities	Redeemable preferred securities	Equity securities	Total
Beginning balance	$ 1	$ 52	$ —	$ —	$ 1	$ 30	$ 84
Net realized and unrealized capital gains (losses):							
Included in earnings	—	(10)	—	—	2	13	5
Included in other comprehensive income	—	(3)	—	—	(1)	—	(4)
Purchases	—	1	—	3	—	13	17
Sales	(1)	(1)	—	—	(2)	(1)	(5)
Settlements	—	(1)	—	—	—	—	(1)
Transfers into Level 3, net	5	—	10	—	—	—	15
Ending balance	$ 5	$ 38	$ 10	$ 3	$ —	$ 55	$ 111

The change in unrealized capital losses included in other comprehensive income associated with Level 3 financial assets which were held as of December 31, 2021 was $4 million during the year ended December 31, 2021.

The changes in the balances of Level 3 financial assets during the year ended December 31, 2020 were as follows:

In millions	States, municipalities and political subdivisions	U.S. corporate securities	Redeemable preferred securities	Equity securities	Total
Beginning balance	$ —	$ 37	$ 12	$ 39	$ 88
Net realized and unrealized capital gains (losses):					
Included in earnings	—	(11)	18	(3)	4
Included in other comprehensive income	—	—	(5)	—	(5)
Purchases	—	27	—	3	30
Sales	—	—	(24)	(9)	(33)
Settlements	—	(1)	—	—	(1)
Transfers into Level 3, net	1	—	—	—	1
Ending balance	$ 1	$ 52	$ 1	$ 30	$ 84

The change in unrealized capital losses included in other comprehensive income associated with Level 3 financial assets which were held as of December 31, 2020 was $4 million during the year ended December 31, 2020.

The total gross transfers into (out of) Level 3 during the years ended December 31, 2021 and 2020 were as follows:

In millions	2021	2020
Gross transfers into Level 3	$ 15	$ 1
Gross transfers out of Level 3	—	—
Net transfers into Level 3	$ 15	$ 1

Financial Instruments Not Measured at Fair Value on the Consolidated Balance Sheets

The carrying value and estimated fair value classified by level of fair value hierarchy for financial instruments carried on the consolidated balance sheets at adjusted cost or contract value at December 31, 2021 and 2020 were as follows:

		Estimated Fair Value			
In millions	Carrying Value	Level 1	Level 2	Level 3	Total
December 31, 2021					
Assets:					
Mortgage loans	$ 902	$ —	$ —	$ 907	$ 907
Equity securities [1]	126	N/A	N/A	N/A	N/A
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	5	—	—	5	5
Without a fixed maturity	336	—	—	373	373
Long-term debt	56,176	64,157	—	—	64,157
December 31, 2020					
Assets:					
Mortgage loans	$ 1,047	$ —	$ —	$ 1,070	$ 1,070
Equity securities [1]	145	N/A	N/A	N/A	N/A
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	5	—	—	5	5
Without a fixed maturity	322	—	—	371	371
Long-term debt	64,647	75,940	—	—	75,940

(1) It was not practical to estimate the fair value of these cost-method investments as it represents shares of unlisted companies. See Note 1 "Significant Accounting Policies" for additional information regarding the valuation of cost method investments.

Separate Accounts Measured at Fair Value on the Consolidated Balance Sheets

Separate Accounts assets relate to the Company's large case pensions products which represent funds maintained to meet specific objectives of contract holders. Since contract holders bear the investment risk of these assets, a corresponding Separate Accounts liability has been established equal to the assets. These assets and liabilities are carried at fair value. Net investment income and capital gains and losses on Separate Accounts assets accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from the Company's other businesses. Deposits, withdrawals, net investment income and realized and unrealized capital gains and losses on Separate Accounts assets are not reflected in the consolidated statements of operations, shareholders' equity or cash flows.

Separate Accounts assets include debt and equity securities. The valuation methodologies used for these assets are similar to the methodologies described above in this Note 4 "Fair Value." Separate Accounts assets also include investments in common/collective trusts that are carried at fair value. Common/collective trusts invest in other investment funds otherwise known as the underlying funds. The Separate Accounts' interests in the common/collective trust funds are based on the fair values of the investments of the underlying funds and therefore are classified in Level 2. The assets in the underlying funds primarily consist of equity securities. Investments in common/collective trust funds are valued at their respective net asset value ("NAV") per share/unit on the valuation date.

Separate Accounts financial assets at December 31, 2021 and 2020 were as follows:

	December 31, 2021				December 31, 2020			
In millions	**Level 1**	**Level 2**	**Level 3**	**Total**	**Level 1**	**Level 2**	**Level 3**	**Total**
Cash and cash equivalents	$ 2	$ 186	$ —	$ 188	$ 2	$ 186	$ —	$ 188
Debt securities	1,233	3,048	—	4,281	1,465	2,634	—	4,099
Equity securities	—	1	—	1	—	2	—	2
Common/collective trusts	—	547	—	547	—	563	—	563
Total [(1)]	$ 1,235	$ 3,782	$ —	$ 5,017	$ 1,467	$ 3,385	$ —	$ 4,852

(1) Excludes $70 million and $29 million of other receivables at December 31, 2021 and 2020, respectively.

During the years ended December 31, 2021 and 2020, the Company had no gross transfers of Separate Accounts financial assets into or out of Level 3.

5. Goodwill and Other Intangibles

Goodwill

Below is a summary of the changes in the carrying amount of goodwill by segment for the years ended December 31, 2021 and 2020:

In millions	**Health Care Benefits**	**Pharmacy Services**	**Retail/ LTC**	**Total**
Balance at December 31, 2019	$ 45,361	$ 23,581	$ 10,807	$ 79,749
Acquisitions	274	34	—	308
Divestiture of Workers' Compensation business	(505)	—	—	(505)
Balance at December 31, 2020	45,130	23,615	10,807	79,552
Impairment	—	—	(431)	(431)
Balance at December 31, 2021	$ 45,130	$ 23,615	$ 10,376	$ 79,121

During the year ended December 31, 2021, the decrease in the carrying amount of goodwill was primarily driven by a goodwill impairment charge related to the LTC reporting unit within the Retail/LTC segment. During the year ended December 31, 2020, the decrease in the carrying amount of goodwill was primarily driven by the divestiture of the Workers' Compensation business, partially offset by goodwill associated with immaterial acquisitions. See Note 2 "Divestitures" for further discussion regarding the Workers' Compensation business divestiture.

During the third quarter of 2021, the Company performed its required annual impairment tests of goodwill. The results of the impairment tests indicated an impairment of the goodwill associated with the LTC reporting unit, as the reporting unit's carrying value exceeded its fair value as of the testing date. The results of the impairment tests of the remaining reporting units indicated that there was no impairment of goodwill as of the testing date.

During 2021, the LTC reporting unit has continued to face challenges that have impacted the Company's ability to grow the LTC reporting unit's business at the rate estimated when its 2020 goodwill impairment test was performed. These challenges include lower net facility admissions, net long-term care facility customer losses and the prolonged adverse impact of the COVID-19 pandemic and the emerging new variants, which resulted in more significant declines in occupancy rates experienced by the Company's long-term care facility customers than previously anticipated. During the third quarter of 2021, LTC management updated their 2021 annual forecast and submitted their long-term plan which showed deterioration in the financial results for the remainder of 2021 and beyond. The Company utilized these updated projections in performing its annual impairment test, which indicated that the fair value of the LTC reporting unit was lower than its carrying value, resulting in a $431 million goodwill impairment charge in the third quarter of 2021. The fair value of the LTC reporting unit was determined using a combination of a discounted cash flow method and a market multiple method. As of December 31, 2021, there was no remaining goodwill balance in the LTC reporting unit. During the third quarter of 2021, the Company also performed an

impairment test of the intangible assets of the LTC reporting unit and concluded these assets were not impaired. As of December 31, 2021, there was $2.7 billion of intangible assets related to customer lists in the LTC reporting unit.

During the third quarter of 2020, the Company performed its required annual impairment tests of goodwill. The results of the impairment tests indicated that there was no impairment of goodwill.

At December 31, 2021 and 2020, cumulative goodwill impairments were $6.6 billion and $6.1 billion, respectively.

Intangible Assets

The following table is a summary of the Company's intangible assets as of December 31, 2021 and 2020:

In millions, except weighted average life	**Gross Carrying Amount**	**Accumulated Amortization**	**Net Carrying Amount**	**Weighted Average Life (years)**
2021				
Trademarks (indefinite-lived)	$ 10,498	$ —	$ 10,498	N/A
Customer contracts/relationships and covenants not to compete	25,084	(10,564)	14,520	15.0
Technology	1,060	(1,060)	—	3.0
Provider networks	4,203	(651)	3,552	20.0
Value of Business Acquired	590	(173)	417	20.0
Other	318	(279)	39	8.4
Total	$ 41,753	$ (12,727)	$ 29,026	15.3
2020				
Trademarks (indefinite-lived)	$ 10,498	$ —	$ 10,498	N/A
Customer contracts/relationships and covenants not to compete	24,952	(8,923)	16,029	14.9
Technology	1,060	(739)	321	3.0
Provider networks	4,203	(440)	3,763	20.0
Value of Business Acquired	590	(119)	471	20.0
Other	320	(260)	60	7.7
Total	$ 41,623	$ (10,481)	$ 31,142	15.2

Amortization expense for intangible assets totaled $2.3 billion, $2.3 billion and $2.4 billion for the years ended December 31, 2021, 2020 and 2019, respectively. The projected annual amortization expense for the Company's intangible assets for the next five years is as follows:

In millions	
2022	$ 1,858
2023	1,826
2024	1,785
2025	1,734
2026	1,494

6. Leases

The Company leases most of its retail stores and mail order facilities and certain distribution centers and corporate offices under operating or finance leases, typically with initial terms of 15 to 25 years. The Company also leases certain equipment and other assets under operating or finance leases, typically with initial terms of 3 to 10 years.

In addition, the Company leases pharmacy space at the stores of another retail chain for which the noncancelable contractual term of the pharmacy lease arrangement exceeds the remaining estimated economic life of the buildings. For these pharmacy lease arrangements, the Company concluded that for accounting purposes the lease term was the

remaining estimated economic life of the buildings. Consequently, most of these individual pharmacy leases are finance leases.

The following table is a summary of the components of net lease cost for the years ended December 31, 2021, 2020 and 2019:

In millions	**2021**	**2020**	**2019**
Operating lease cost	$ 2,633	$ 2,670	$ 2,720
Finance lease cost:			
Amortization of right-of-use assets	62	56	38
Interest on lease liabilities	62	58	44
Total finance lease costs	124	114	82
Short-term lease costs	25	22	24
Variable lease costs	604	599	581
Less: sublease income	59	55	50
Net lease cost	$ 3,327	$ 3,350	$ 3,357

Supplemental cash flow information related to leases for the years ended December 31, 2021, 2020 and 2019 is as follows:

In millions	**2021**	**2020**	**2019**
Cash paid for amounts included in the measurement of lease liabilities:			
Operating cash flows paid for operating leases	$ 2,714	$ 2,724	$ 2,701
Operating cash flows paid for interest portion of finance leases	62	58	44
Financing cash flows paid for principal portion of finance leases	50	34	26
Right-of-use assets obtained in exchange for lease obligations:			
Operating leases	1,254	1,679	1,824
Finance leases	278	313	283

Supplemental balance sheet information related to leases as of December 31, 2021 and 2020 is as follows:

In millions, except remaining lease term and discount rate	**2021**	**2020**
Operating leases:		
Operating lease right-of-use assets	$ 19,122	$ 20,729
Current portion of operating lease liabilities	$ 1,646	$ 1,638
Long-term operating lease liabilities	18,177	18,757
Total operating lease liabilities	$ 19,823	$ 20,395
Finance leases:		
Property and equipment, gross	$ 1,375	$ 1,107
Accumulated depreciation	(188)	(106)
Property and equipment, net	$ 1,187	$ 1,001
Current portion of long-term debt	$ 50	$ 33
Long-term debt	1,250	1,050
Total finance lease liabilities	$ 1,300	$ 1,083
Weighted average remaining lease term *(in years)*		
Operating leases	12.8	13.3
Finance leases	20.0	20.3
Weighted average discount rate		
Operating leases	4.4 %	4.5 %
Finance leases	5.0 %	5.6 %

The following table summarizes the maturity of lease liabilities under finance and operating leases as of December 31, 2021:

In millions	**Finance Leases**	**Operating Leases [1]**	**Total**
2022	$ 122	$ 2,685	$ 2,807
2023	121	2,613	2,734
2024	111	2,398	2,509
2025	110	2,217	2,327
2026	109	2,054	2,163
Thereafter	1,495	14,103	15,598
Total lease payments [2]	2,068	26,070	28,138
Less: imputed interest	(768)	(6,247)	(7,015)
Total lease liabilities	$ 1,300	$ 19,823	$ 21,123

(1) Future operating lease payments have not been reduced by minimum sublease rentals of $311 million due in the future under noncancelable subleases.

(2) The Company leases pharmacy and clinic space from Target Corporation. Amounts related to such finance and operating leases are reflected above. Pharmacy lease amounts due in excess of the remaining estimated economic life of the buildings of approximately $2.4 billion are not reflected in this table since the estimated economic life of the buildings is shorter than the contractual term of the pharmacy lease arrangement.

Sale-Leaseback Transactions

The Company finances a portion of its store development program through sale-leaseback transactions. The properties are generally sold at net book value, which generally approximates fair value, and the resulting leases generally qualify and are accounted for as operating leases. The operating leases that resulted from these transactions are included in the tables above. The Company does not have any retained or contingent interests in the stores and does not provide any guarantees, other than a

guarantee of lease payments, in connection with the sale-leaseback transactions. There were no sale-leaseback transactions in 2021. Proceeds from sale-leaseback transactions totaled $101 million and $5 million in the years ended December 31, 2020 and 2019, respectively. Gains from sale-leaseback transactions totaled $3 million in the year ended December 31, 2020. There were no material gains from sale-leaseback transactions in the year ended December 31, 2019.

Store Impairment Charges
The Company evaluates its retail store right-of-use and property and equipment assets for impairment at the retail store level, which is the lowest level at which cash flows can be identified. For retail stores where there is an indicator of impairment present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted). If the estimated undiscounted future cash flows used in the analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to its estimated fair value which is the greater of the asset group's estimated future cash flows (discounted), or the consideration of what a market participant would pay to lease the assets, net of leasing costs. The Company's estimate of fair value considers historical results, current operating trends, consolidated sales, profitability and cash flow results and forecasts. For assets which the Company has determined it will be able to sublease, the estimated future cash flows include the estimated sublease income, net of estimated leasing costs.

When the carrying value of an asset group exceeds its estimated fair value, an impairment loss is recorded to reduce the value of the asset group to its estimated fair value. As the impaired assets are measured at fair value on a nonrecurring basis primarily using unobservable inputs as of the measurement date, the assets are classified in Level 3 of the fair value hierarchy.

During the fourth quarter of 2021, the Company completed a strategic review of its retail business and announced the creation of new formats for its stores to continue to drive higher engagement with customers. As part of this review, the Company evaluated changes in population, consumer buying patterns and future health needs to ensure it has the right kinds of stores in the right locations for consumers and for the business. In connection with this initiative, on November 17, 2021, the Board of Directors of CVS Health Corporation (the "Board") authorized the closing of approximately 900 retail stores over the next three years. The Company expects to close approximately 300 stores each year between 2022 and 2024. As a result, management determined that there were indicators of impairment with respect to the impacted stores' asset groups, including the associated operating lease right-of-use assets and property and equipment. A long-lived asset impairment test was performed during the fourth quarter of 2021 and the results of the impairment test indicated that the fair value of certain retail store asset groups was lower than their respective carrying values. Accordingly, in the three months ended December 31, 2021, the Company recorded a store impairment charge of approximately $1.4 billion, consisting of a write down of approximately $1.1 billion related to operating lease right-of-use assets and $261 million related to property and equipment, within the Retail/LTC segment. Subsequent to the impairment loss, the fair value of the associated operating lease right-of use assets and property and equipment were $356 million and $185 million, respectively.

During 2019, the Company performed reviews of its retail stores and determined it would close 68 underperforming retail pharmacy stores. As a result, management determined that there were indicators of impairment with respect to the impacted stores, including the associated operating lease right-of-use assets. Long-lived asset impairment tests were performed and the results indicated that the fair value of those underperforming retail stores were lower than their respective carrying values. Accordingly, the Company recorded store impairment charges of $231 million during the year ended December 31, 2019, primarily related to these operating lease right-of-use asset impairment charges, within the Retail/LTC segment.

7. Health Care Costs Payable

The following is information about incurred and cumulative paid health care claims development as of December 31, 2021, net of reinsurance, and the total IBNR liabilities plus expected development on reported claims included within the net incurred claims amounts. See Note 1 ‘‘Significant Accounting Policies’’ for information on how the Company estimates IBNR reserves and health care costs payable as well as changes to those methodologies, if any. The Company’s estimate of IBNR liabilities is primarily based on trend and completion factors. Claim frequency is not used in the calculation of the Company’s liability. In addition, it is impracticable to disclose claim frequency information for health care claims due to the Company’s inability to gather consistent claim frequency information across its multiple claims processing systems. Any claim frequency count disclosure would not be comparable across the Company’s different claim processing systems and would not be consistent from period to period based on the volume of claims processed through each system. As a result, health care claim count frequency is not included in the disclosures below.

The information about incurred and paid health care claims development for the year ended December 31, 2020 is presented as required unaudited supplemental information.

In millions	**Incurred Health Care Claims, Net of Reinsurance For the Years Ended December 31,**	
Date of Service	**2020**	**2021**
	(Unaudited)	
2020	$ 54,529	$ 53,804
2021		62,830
	Total	$ 116,634

In millions	**Cumulative Paid Health Care Claims, Net of Reinsurance For the Years Ended December 31,**	
Date of Service	**2020**	**2021**
	(Unaudited)	
2020	$ 47,567	$ 53,590
2021		54,600
	Total	$ 108,190
All outstanding liabilities for health care costs payable prior to 2020, net of reinsurance		130
Total outstanding liabilities for health care costs payable, net of reinsurance		$ 8,574

At December 31, 2021, the Company’s liabilities for IBNR plus expected development on reported claims totaled approximately $6.6 billion. Substantially all of the Company’s liabilities for IBNR plus expected development on reported claims at December 31, 2021 related to the current calendar year.

The reconciliation of the December 31, 2021 health care net incurred and paid claims development tables to the health care costs payable liability on the consolidated balance sheet is as follows:

In millions	December 31, 2021
Short-duration health care costs payable, net of reinsurance	$ 8,574
Reinsurance recoverables	8
Premium deficiency reserve	16
Insurance lines other than short duration	210
Total health care costs payable	$ 8,808

The following table shows the components of the change in health care costs payable during the years ended December 31, 2021, 2020 and 2019:

In millions	**2021**	**2020**	**2019**
Health care costs payable, beginning of period	$ 7,936	$ 6,879	$ 6,147
Less: Reinsurance recoverables	10	5	4
Health care costs payable, beginning of period, net	7,926	6,874	6,143
Acquisitions, net	—	414	—
Add: Components of incurred health care costs			
Current year	64,761	55,835	52,723
Prior years	(788)	(429)	(524)
Total incurred health care costs [(1)]	63,973	55,406	52,199
Less: Claims paid			
Current year	56,323	48,770	46,158
Prior years	6,792	6,009	5,314
Total claims paid	63,115	54,779	51,472
Add: Premium deficiency reserve	16	11	4
Health care costs payable, end of period, net	8,800	7,926	6,874
Add: Reinsurance recoverables	8	10	5
Health care costs payable, end of period	$ 8,808	$ 7,936	$ 6,879

(1) Total incurred health care costs for the years ended December 31, 2021, 2020 and 2019 in the table above exclude (i) $16 million, $11 million and $4 million, respectively, for a premium deficiency reserve related to the Company's Medicaid products, (ii) $59 million, $41 million and $41 million, respectively, of benefit costs recorded in the Health Care Benefits segment that are included in other insurance liabilities on the consolidated balance sheets and (iii) $212 million, $221 million and $285 million, respectively, of benefit costs recorded in the Corporate/Other segment that are included in other insurance liabilities on the consolidated balance sheets.

The Company's estimates of prior years' health care costs payable decreased by $788 million, $429 million and $524 million in 2021, 2020 and 2019, respectively, because claims were settled for amounts less than originally estimated (i.e., the amount of claims incurred was lower than originally estimated), primarily due to lower health care cost trends as well as the actual claim submission time being faster than originally assumed (i.e., the Company's completion factors were higher than originally assumed) in estimating health care costs payable at the end of the prior year. This development does not directly correspond to an increase in the Company's operating results as these reductions were offset by estimated current period health care costs when the Company established the estimate of the current year health care costs payable.

8. Borrowings and Credit Agreements

The following table is a summary of the Company's borrowings as of December 31, 2021 and 2020:

In millions	**2021**	**2020**
Long-term debt		
3.35% senior notes due March 2021	$ —	$ 2,038
Floating rate notes due March 2021 (0.950% at December 31, 2020)	—	1,000
4.125% senior notes due May 2021	—	222
2.125% senior notes due June 2021	—	1,750
4.125% senior notes due June 2021	—	203
5.45% senior notes due June 2021	—	187
3.5% senior notes due July 2022	1,500	1,500
2.75% senior notes due November 2022	1,000	1,000
2.75% senior notes due December 2022	1,250	1,250
4.75% senior notes due December 2022	399	399
3.7% senior notes due March 2023	—	2,336
2.8% senior notes due June 2023	1,300	1,300
4% senior notes due December 2023	414	414
3.375% senior notes due August 2024	650	650
2.625% senior notes due August 2024	1,000	1,000
3.5% senior notes due November 2024	750	750
5% senior notes due December 2024	299	299
4.1% senior notes due March 2025	950	950
3.875% senior notes due July 2025	2,828	2,828
2.875% senior notes due June 2026	1,750	1,750
3% senior notes due August 2026	750	750
3.625% senior notes due April 2027	750	750
6.25% senior notes due June 2027	372	372
1.3% senior notes due August 2027	2,250	2,250
4.3% senior notes due March 2028	5,000	7,050
3.25% senior notes due August 2029	1,750	1,750
3.75% senior notes due April 2030	1,500	1,500
1.75% senior notes due August 2030	1,250	1,250
1.875% senior notes due February 2031	1,250	1,250
2.125% senior notes due September 2031	1,000	—
4.875% senior notes due July 2035	652	652
6.625% senior notes due June 2036	771	771
6.75% senior notes due December 2037	533	533
4.78% senior notes due March 2038	5,000	5,000
6.125% senior notes due September 2039	447	447
4.125% senior notes due April 2040	1,000	1,000
2.7% senior notes due August 2040	1,250	1,250
5.75% senior notes due May 2041	133	133
4.5% senior notes due May 2042	500	500
4.125% senior notes due November 2042	500	500
5.3% senior notes due December 2043	750	750
4.75% senior notes due March 2044	375	375
5.125% senior notes due July 2045	3,500	3,500
3.875% senior notes due August 2047	1,000	1,000
5.05% senior notes due March 2048	8,000	8,000
4.25% senior notes due April 2050	750	750
Finance lease liabilities	1,300	1,083
Other	320	326
Total debt principal	56,743	65,318
Debt premiums	219	238
Debt discounts and deferred financing costs	(786)	(909)
	56,176	64,647
Less:		
Current portion of long-term debt	(4,205)	(5,440)

The following is a summary of the Company's required repayments of debt principal due during each of the next five years and thereafter, as of December 31, 2021:

In millions	
2022	$ 4,154
2023	1,719
2024	2,706
2025	3,785
2026	2,507
Thereafter	40,572
Subtotal	55,443
Finance lease liabilities [(1)]	1,300
Total debt principal	$ 56,743

(1) See Note 6 "Leases" for a summary of maturities of the Company's finance lease liabilities.

Short-term Borrowings

Commercial Paper and Back-up Credit Facilities
The Company did not have any commercial paper outstanding as of December 31, 2021 or 2020. In connection with its commercial paper program, the Company maintains a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 17, 2023, a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 16, 2024, and a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 11, 2026. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately 0.03%, regardless of usage. As of December 31, 2021 and 2020, there were no borrowings outstanding under any of the Company's back-up credit facilities.

Federal Home Loan Bank of Boston ("FHLBB")
A subsidiary of the Company is a member of the FHLBB. As a member, the subsidiary has the ability to obtain cash advances, subject to certain minimum collateral requirements. The maximum borrowing capacity available from the FHLBB as of December 31, 2021 was approximately $995 million. At both December 31, 2021 and 2020, there were no outstanding advances from the FHLBB.

Long-term Borrowings

2021 Notes
On August 18, 2021, the Company issued $1.0 billion aggregate principal amount of 2.125% unsecured senior notes due September 15, 2031 for total proceeds of $987 million, net of discounts, underwriting fees and offering expenses. The net proceeds of this offering were used for the purchase of senior notes in connection with the Company's cash tender offer in August 2021 as described below.

2020 Notes
On December 16, 2020, the Company issued $750 million aggregate principal amount of 1.3% unsecured senior notes due August 21, 2027 and $1.25 billion aggregate principal amount of 1.875% unsecured senior notes due February 28, 2031 for total proceeds of approximately $1.99 billion, net of discounts and underwriting fees. The $750 million aggregate principal amount of 1.3% unsecured senior notes represent a further issuance of the Company's 1.3% unsecured senior notes due August 21, 2027 initially issued in an aggregate principal amount of $1.5 billion on August 21, 2020.

On August 21, 2020, the Company issued $1.5 billion aggregate principal amount of 1.3% unsecured senior notes due August 21, 2027, $1.25 billion aggregate principal amount of 1.75% unsecured senior notes due August 21, 2030 and $1.25 billion aggregate principal amount of 2.7% unsecured senior notes due August 21, 2040 (collectively, the "August 2020 Notes") for total proceeds of approximately $3.97 billion, net of discounts and underwriting fees.

On March 31, 2020, the Company issued $750 million aggregate principal amount of 3.625% unsecured senior notes due April 1, 2027, $1.5 billion aggregate principal amount of 3.75% unsecured senior notes due April 1, 2030, $1.0 billion aggregate principal amount of 4.125% unsecured senior notes due April 1, 2040 and $750 million aggregate principal amount of 4.25%

unsecured senior notes due April 1, 2050 (collectively, the "March 2020 Notes") for total proceeds of approximately $3.95 billion, net of discounts and underwriting fees.

The net proceeds of these offerings were used for general corporate purposes, which may include working capital, capital expenditures, as well as the repurchase and/or repayment of indebtedness.

During March 2020, the Company entered into several interest rate swap transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of the March 2020 Notes. In connection with the issuance of the March 2020 Notes, the Company terminated all outstanding cash flow hedges. The Company paid a net amount of $7 million to the hedge counterparties upon termination, which was recorded as a loss, net of tax, of $5 million in accumulated other comprehensive income and will be reclassified as interest expense over the life of the March 2020 Notes. See Note 13 "Other Comprehensive Income" for additional information.

Early Extinguishments of Debt
In December 2021, the Company redeemed for cash the remaining $2.3 billion of its outstanding 3.7% senior notes due 2023. In connection with the early redemption of such senior notes, the Company paid a make-whole premium of $80 million in excess of the aggregate principal amount of the senior notes that were redeemed, wrote-off $8 million of unamortized deferred financing costs and incurred $1 million in fees, for a total loss on early extinguishment of debt of $89 million.

In August 2021, the Company purchased approximately $2.0 billion of its outstanding 4.3% senior notes due 2028 through a cash tender offer. In connection with the purchase of such senior notes, the Company paid a premium of $332 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $26 million of unamortized deferred financing costs and incurred $5 million in fees, for a total loss on early extinguishment of debt of $363 million.

In December 2020, the Company purchased $4.5 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $113 million of its 4.0% senior notes due 2023, $1.4 billion of its 3.7% senior notes due 2023, $1.0 billion of its 4.1% senior notes due 2025 and $2.0 billion of its 4.3% senior notes due 2028. In connection with the purchase of such senior notes, the Company paid a premium of $619 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $45 million of unamortized deferred financing costs and incurred $10 million in fees, for a total loss on early extinguishment of debt of $674 million.

In August 2020, the Company purchased $6.0 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $723 million of its 4.0% senior notes due 2023, $2.3 billion of its 3.7% senior notes due 2023 and $3.0 billion of its 4.1% senior notes due 2025. In connection with the purchase of such senior notes, the Company paid a premium of $706 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $47 million of unamortized deferred financing costs and incurred $13 million in fees, for a total loss on early extinguishment of debt of $766 million.

In August 2019, the Company purchased $4.0 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $1.3 billion of its 3.125% senior notes due 2020, $723 million of its floating rate notes due 2020, $328 million of its 4.125% senior notes due 2021, $297 million of 4.125% senior notes due 2021 issued by Aetna Inc. ("Aetna"), $413 million of 5.45% senior notes due 2021 issued by Coventry Health Care, Inc., a wholly-owned subsidiary of Aetna, and $962 million of its 3.35% senior notes due 2021. In connection with the purchase of such senior notes, the Company paid a premium of $76 million in excess of the aggregate principal amount of the senior notes that were purchased, incurred $8 million in fees and recognized a net gain of $5 million on the write-off of net unamortized deferred financing premiums, for a net loss on early extinguishment of debt of $79 million.

Debt Covenants

The Company's back-up revolving credit facilities, unsecured senior notes and unsecured floating rate notes contain customary restrictive financial and operating covenants. These covenants do not include an acceleration of the Company's debt maturities in the event of a downgrade in the Company's credit ratings. The Company does not

believe the restrictions contained in these covenants materially affect its financial or operating flexibility. As of December 31, 2021, the Company was in compliance with all of its debt covenants.

9. Pension Plans and Other Postretirement Benefits

Defined Contribution Plans

As of December 31, 2021, the Company sponsors several active 401(k) savings plans that cover all employees who meet plan eligibility requirements.

The Company makes matching contributions consistent with the provisions of the respective plans. At the participant's option, account balances, including the Company's matching contribution, can be invested among various investment options under each plan. The CVS Health Future Fund 401(k) Plan offers CVS Health Corporation's common stock fund as an investment option. The Company also maintains nonqualified, unfunded deferred compensation plans for certain key employees. The plans provide participants the opportunity to defer portions of their eligible compensation and for certain nonqualified plans, participants receive matching contributions equivalent to what they could have received under the CVS Health Future Fund 401(k) Plan absent certain restrictions and limitations under the Internal Revenue Code. The Company's contributions under its defined contribution plans were $552 million, $520 million and $550 million in the years ended December 31, 2021, 2020 and 2019, respectively. The Company's contributions for the year ended December 31, 2019 include contributions to the Aetna 401(k) Plan, which was merged into the CVS Health Future Fund 401(k) Plan on January 1, 2020.

Defined Benefit Pension Plans

The Company sponsors a tax-qualified defined benefit pension plan that was frozen in 2010 and a nonqualified supplemental pension plan that was frozen in 2007. The Company also sponsors several other defined benefit pension plans that are unfunded nonqualified supplemental retirement plans.

Pension Benefit Obligation and Plan Assets
The following tables outline the change in pension benefit obligation and plan assets over the specified periods:

In millions	**2021**	**2020**
Change in benefit obligation:		
Benefit obligation, beginning of year	$ 6,462	$ 6,239
Interest cost	110	168
Actuarial (gain) loss	(102)	413
Benefit payments	(408)	(358)
Settlements	(53)	—
Benefit obligation, end of year	6,009	6,462
Change in plan assets:		
Fair value of plan assets, beginning of year	6,845	6,395
Actual return on plan assets	215	783
Employer contributions	78	25
Benefit payments	(408)	(358)
Settlements	(53)	—
Fair value of plan assets, end of year	6,677	6,845
Funded status	$ 668	$ 383

The change in the pension benefit obligation during the years ended December 31, 2021 and 2020 was primarily driven by the change in the discount rate during each respective period.

The assets (liabilities) recognized on the consolidated balance sheets at December 31, 2021 and 2020 for the defined benefit pension plans consisted of the following:

In millions	**2021**	**2020**
Noncurrent assets reflected in other assets	$ 946	$ 744
Current liabilities reflected in accrued expenses	(28)	(76)
Noncurrent liabilities reflected in other long-term liabilities	(250)	(285)
Net assets	$ 668	$ 383

Net Periodic Benefit Cost (Income)
The components of net periodic benefit cost (income) for the years ended December 31, 2021, 2020 and 2019 are shown below:

In millions	**2021**	**2020**	**2019**
Components of net periodic benefit cost (income):			
Interest cost	$ 110	$ 168	$ 225
Expected return on plan assets	(317)	(388)	(357)
Amortization of net actuarial loss	5	2	1
Settlement losses	16	—	—
Net periodic benefit cost (income)	$ (186)	$ (218)	$ (131)

Pension Plan Assumptions
The Company uses a series of actuarial assumptions to determine its benefit obligation and net periodic benefit cost (income), the most significant of which include discount rates and expected return on plan assets assumptions.

Discount Rates - The discount rate is determined using a yield curve as of the annual measurement date. The yield curve consists of a series of individual discount rates, with each discount rate corresponding to a single point in time, based on high-quality bonds. Projected benefit payments are discounted to the measurement date using the corresponding rate from the yield curve that is consistent with the maturity profile of the expected liability cash flows.

Expected Return on Plan Assets - The expected long-term rate of return on plan assets is determined by using the plan's target allocation and return expectations based on many factors including forecasted long-term capital market real returns and the inflationary outlook on a plan by plan basis. See "Pension Plan Assets" below for additional details regarding the pension plan assets as of December 31, 2021 and 2020.

The Company also considers other assumptions including mortality, interest crediting rate, termination and retirement rates and cost of living adjustments.

The Company determined its benefit obligation based on the following weighted average assumptions as of December 31, 2021 and 2020:

	2021	**2020**
Discount rate	2.8 %	2.5 %

The Company determined its net periodic benefit cost (income) based on the following weighted average assumptions for the years ended December 31, 2021, 2020 and 2019:

	2021	**2020**	**2019**
Discount rate	1.8 %	2.9 %	4.0 %
Expected long-term rate of return on plan assets	4.8 %	6.3 %	6.5 %

Pension Plan Assets

The Company's pension plan assets primarily include debt and equity securities held in separate accounts, common/collective trusts and real estate investments. The valuation methodologies used to value these debt and equity securities and common/collective trusts are similar to the methodologies described in Note 4 "Fair Value." Pension plan assets also include investments in other assets that are carried at fair value. The following is a description of the valuation methodologies used to value real estate investments and these additional investments, including the general classification pursuant to the fair value hierarchy.

Real Estate - Real estate investments are valued by independent third party appraisers. The appraisals comply with the Uniform Standards of Professional Appraisal Practice, which include, among other things, the income, cost, and sales comparison approaches to estimating property value. Therefore, these investments are classified in Level 3.

Private equity and hedge fund limited partnerships - Private equity and hedge fund limited partnerships are carried at fair value which is estimated using the NAV per unit as reported by the administrator of the underlying investment fund as a practical expedient to fair value. Therefore, these investments have been excluded from the fair value table below.

Pension plan assets with changes in fair value measured on a recurring basis at December 31, 2021 were as follows:

In millions	**Level 1**	**Level 2**	**Level 3**	**Total**
Cash and cash equivalents	$ 60	$ 97	$ —	$ 157
Debt securities:				
U.S. government securities	1,223	1	—	1,224
States, municipalities and political subdivisions	—	150	—	150
U.S. corporate securities	—	2,458	—	2,458
Foreign securities	—	202	—	202
Residential mortgage-backed securities	—	277	—	277
Commercial mortgage-backed securities	—	76	—	76
Other asset-backed securities	—	162	—	162
Redeemable preferred securities	—	4	—	4
Total debt securities	1,223	3,330	—	4,553
Equity securities:				
U.S. domestic	201	—	—	201
International	81	—	—	81
Domestic real estate	1	—	—	1
Total equity securities	283	—	—	283
Other investments:				
Real estate	—	—	378	378
Common/collective trusts [(1)]	—	410	—	410
Total other investments	—	410	378	788
Total pension investments [(2)]	$ 1,566	$ 3,837	$ 378	$ 5,781

(1) The assets in the underlying funds of common/collective trusts consist of $261 million of equity securities and $149 million of debt securities.

(2) Excludes $76 million of other receivables as well as $583 million of private equity limited partnership investments and $237 million of hedge fund limited partnership investments as these amounts are measured at NAV per share or an equivalent and are not subject to leveling within the fair value hierarchy.

Pension plan assets with changes in fair value measured on a recurring basis at December 31, 2020 were as follows:

In millions	**Level 1**	**Level 2**	**Level 3**	**Total**
Cash and cash equivalents	$ 118	$ 81	$ —	$ 199
Debt securities:				
U.S. government securities	575	36	—	611
States, municipalities and political subdivisions	—	170	—	170
U.S. corporate securities	—	2,006	—	2,006
Foreign securities	—	167	—	167
Residential mortgage-backed securities	—	287	—	287
Commercial mortgage-backed securities	—	83	—	83
Other asset-backed securities	—	133	—	133
Redeemable preferred securities	—	5	—	5
Total debt securities	575	2,887	—	3,462
Equity securities:				
U.S. domestic	1,046	—	—	1,046
International	537	—	—	537
Domestic real estate	15	—	—	15
Total equity securities	1,598	—	—	1,598
Other investments:				
Real estate	—	—	343	343
Common/collective trusts [1]	—	266	—	266
Derivatives	—	(3)	—	(3)
Total other investments	—	263	343	606
Total pension investments [2]	$ 2,291	$ 3,231	$ 343	$ 5,865

(1) The assets in the underlying funds of common/collective trusts consist of $84 million of equity securities and $182 million of debt securities.

(2) Excludes $142 million of other receivables as well as $624 million of private equity limited partnership investments and $214 million of hedge fund limited partnership investments as these amounts are measured at NAV per share or an equivalent and are not subject to leveling within the fair value hierarchy.

The changes in the balances of Level 3 pension plan assets during the year ended December 31, 2021 were as follows:

In millions	**Real estate**	**Total**
Beginning balance	$ 343	$ 343
Actual return on plan assets	43	43
Purchases, sales and settlements	(8)	(8)
Transfers out of Level 3	—	—
Ending balance	$ 378	$ 378

The changes in the balances of Level 3 pension plan assets during the year ended December 31, 2020 were as follows:

In millions	**Real estate**	**U.S. corporate securities**	**Total**
Beginning balance	$ 353	$ 1	$ 354
Actual return on plan assets	(2)	—	(2)
Purchases, sales and settlements	(8)	—	(8)
Transfers out of Level 3	—	(1)	(1)
Ending balance	$ 343	$ —	$ 343

The Company's pension plan invests in a diversified mix of assets designed to generate returns that will enable the plan to meet its future benefit obligations. The risk of unexpected investment and actuarial outcomes is regularly evaluated. This evaluation is performed through forecasting and assessing ranges of investment outcomes over short- and long-term horizons and by assessing the pension plan's liability characteristics. Complementary investment styles and strategies are utilized by professional investment management firms to further improve portfolio and operational risk characteristics. Public and private equity investments are used primarily to increase overall plan returns. Real estate investments are viewed favorably for their diversification benefits and above-average dividend generation. Fixed income investments provide diversification benefits and liability hedging attributes that are desirable, especially in falling interest rate environments.

At December 31, 2021, target investment allocations for the Company's pension plan were: 12% in equity securities, 77% in fixed income and debt securities, 5% in real estate, 3% in private equity limited partnerships and 3% in hedge funds. Actual asset allocations may differ from target allocations due to tactical decisions to overweight or underweight certain assets or as a result of normal fluctuations in asset values. Asset allocations are consistent with stated investment policies and, as a general rule, periodically rebalanced back to target asset allocations. Asset allocations and investment performance are formally reviewed periodically throughout the year by the pension plan's Investment Subcommittee. Forecasting of asset and liability growth is performed at least annually.

Cash Flows
The Company generally contributes to its tax-qualified pension plan based on minimum funding requirements determined under applicable federal laws and regulations. Employer contributions related to the nonqualified supplemental pension plans generally represent payments to retirees for current benefits. The Company contributed $78 million, $25 million and $25 million to its pension plans during 2021, 2020 and 2019, respectively. No contributions are required for the tax-qualified pension plan in 2022. The Company expects to make an immaterial amount of contributions for all other pension plans in 2022.

The Company estimates the following future benefit payments, which are calculated using the same actuarial assumptions used to measure the pension benefit obligation as of December 31, 2021:

In millions		
2022	$	371
2023		371
2024		371
2025		371
2026		368
2027-2031		1,776

Multiemployer Pension Plans
The Company also contributes to a number of multiemployer pension plans under the terms of collective-bargaining agreements that cover its union-represented employees. The risks of participating in these multiemployer plans are different from single-employer pension plans in the following respects: (i) assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers, (ii) if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers, and (iii) if the Company chooses to stop participating in some of its multiemployer plans, the Company may be required to pay those plans an amount based on the underfunded status of the applicable plan, which is referred to as a withdrawal liability.

None of the multiemployer pension plans in which the Company participates are individually significant to the Company. The Company's contributions to multiemployer pension plans were $19 million, $19 million and $18 million in 2021, 2020 and 2019, respectively.

Other Postretirement Benefits

The Company provides postretirement health care and life insurance benefits to certain retirees who meet eligibility requirements. The Company's funding policy is generally to pay covered expenses as they are incurred. For retiree medical plan accounting, the Company reviews external data and its own historical trends for health care costs to

determine the health care cost trend rates. As of December 31, 2021 and 2020, the Company's other postretirement benefits had an accumulated postretirement benefit obligation of $207 million and $226 million, respectively. Net periodic benefit costs related to these other postretirement benefits were $4 million, $12 million and $7 million in 2021, 2020 and 2019, respectively.

The Company estimates the following future benefit payments, which are calculated using the same actuarial assumptions used to measure the accumulated other postretirement benefit obligation as of December 31, 2021:

In millions	
2022	$ 12
2023	12
2024	12
2025	12
2026	12
2027-2031	60

Pursuant to various collective bargaining agreements, the Company also contributes to multiemployer health and welfare plans that cover certain union-represented employees. The plans provide postretirement health care and life insurance benefits to certain employees who meet eligibility requirements. The Company's contributions to multiemployer health and welfare plans totaled $60 million, $54 million and $57 million in 2021, 2020 and 2019, respectively.

10. Income Taxes

The income tax provision for continuing operations consisted of the following for the years ended December 31, 2021, 2020 and 2019:

In millions	**2021**	**2020**	**2019**
Current:			
Federal	$ 2,285	$ 2,615	$ 2,450
State	665	518	565
	2,950	3,133	3,015
Deferred:			
Federal	(306)	(450)	(535)
State	(122)	(114)	(114)
	(428)	(564)	(649)
Total	$ 2,522	$ 2,569	$ 2,366

The following table is a reconciliation of the statutory income tax rate to the Company's effective income tax rate for continuing operations for the years ended December 31, 2021, 2020 and 2019:

	2021	**2020**	**2019**
Statutory income tax rate	21.0 %	21.0 %	21.0 %
State income taxes, net of federal tax benefit	4.1	3.2	4.0
Health insurer fee	—	2.2	—
Basis difference upon disposition of subsidiary	—	(1.2)	—
Prior year refund claim	(1.2)	—	—
Other	0.3	1.1	1.3
Effective income tax rate	24.2 %	26.3 %	26.3 %

The following table is a summary of the components of the Company's deferred income tax assets and liabilities as of December 31, 2021 and 2020:

In millions	**2021**	**2020**
Deferred income tax assets:		
Lease and rents	$ 5,563	$ 5,742
Inventory	99	80
Employee benefits	193	238
Bad debts and other allowances	489	395
Net operating loss and capital loss carryforwards	416	568
Deferred income	78	43
Insurance reserves	501	489
Payroll tax deferral	87	173
Other	396	500
Valuation allowance	(325)	(454)
Total deferred income tax assets	7,497	7,774
Deferred income tax liabilities:		
Retirement benefits	(105)	(29)
Investments	(334)	(421)
Lease and rents	(4,947)	(5,368)
Depreciation and amortization	(8,381)	(8,750)
Total deferred income tax liabilities	(13,767)	(14,568)
Net deferred income tax liabilities	$ (6,270)	$ (6,794)

As of December 31, 2021, the Company had net operating and capital loss carryovers of $416 million, which expire between 2022 and 2041. The Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax planning strategies and the Company's recent operating results. The Company established a valuation allowance of $325 million as of December 31, 2021 because it does not consider it more likely than not that these deferred tax assets will be recovered.

A reconciliation of the beginning and ending balance of unrecognized tax benefits in 2021, 2020 and 2019 is as follows:

In millions	**2021**	**2020**	**2019**
Beginning balance	$ 768	$ 655	$ 661
Additions based on tax positions related to the current year	3	3	4
Additions based on tax positions related to prior years	52	182	115
Reductions for tax positions of prior years	(33)	(56)	(111)
Expiration of statutes of limitation	(1)	(2)	(7)
Settlements	(7)	(14)	(7)
Ending balance	$ 782	$ 768	$ 655

CVS Health Corporation and most of its subsidiaries are subject to U.S. federal income tax as well as income tax of numerous state and local jurisdictions. CVS Health Corporation participated in the Compliance Assurance Process through 2019, which is a program made available by the U.S. Internal Revenue Service ("IRS") to certain qualifying large taxpayers, under which participants work collaboratively with the IRS to identify and resolve potential tax issues through open, cooperative and transparent interaction prior to the annual filing of their federal income tax returns. The IRS has completed its examinations of the Company's consolidated U.S. federal income tax returns for tax years through and including 2013 and 2018. The IRS has substantially completed its examinations of the Company's consolidated U.S. federal income tax returns for tax years 2014 through 2017 and 2019.

CVS Health Corporation and its subsidiaries are also currently under income tax examinations by a number of state and local tax authorities. As of December 31, 2021, no examination has resulted in any proposed adjustments that would result in a material change to the Company's operating results, financial condition or liquidity.

Substantially all material state and local income tax matters have been concluded for fiscal years through 2014. Certain state exams are likely to be concluded and certain state statutes of limitations will lapse in 2022, but the change in the balance of the Company's uncertain tax positions is projected to be immaterial. In addition, it is reasonably possible that the Company's unrecognized tax benefits could change within the next twelve months due to the anticipated conclusion of various examinations with the IRS for various years. An estimate of the range of the possible change cannot be made at this time.

The Company records interest expense related to unrecognized tax benefits and penalties in the income tax provision. The Company accrued interest expense of approximately $40 million, $34 million and $49 million in 2021, 2020 and 2019, respectively. The Company had approximately $151 million and $121 million accrued for interest and penalties as of December 31, 2021 and 2020, respectively.

As of December 31, 2021, the total amount of unrecognized tax benefits that, if recognized, would affect the Company's effective income tax rate is approximately $669 million, after considering the federal benefit of state income taxes.

11. Stock Incentive Plans

The terms of the CVS Health 2017 Incentive Compensation Plan ("ICP") provide for grants of annual incentive and long-term performance awards to executive officers and other officers and employees of the Company or any subsidiary of the Company, as well as equity compensation to outside directors of CVS Health Corporation. Payment of such annual incentive and long-term performance awards will be in cash, stock, other awards or other property, at the discretion of the Management Planning and Development Committee (the "MP&D Committee") of the Board. The ICP allows for a maximum of 58 million shares of CVS Health Corporation common stock to be reserved and available for grants. As of December 31, 2021, there were approximately 30 million shares of CVS Health Corporation common stock available for future grants under the ICP.

Upon the acquisition of Aetna (the "Aetna Acquisition") on November 28, 2018, approximately 22 million shares of Aetna common stock subject to awards outstanding under the Amended Aetna Inc. 2010 Stock Incentive Plan ("SIP") were assumed by CVS Health Corporation. In addition, in accordance with the merger agreement, shares which were available for future issuance under the SIP were converted into approximately 32 million shares of CVS Health Corporation common stock reserved and available for issuance pursuant to future awards. Subsequent to the expiration of the SIP on May 21, 2020, the ICP is the only compensation plan under which the Company grants stock options, restricted stock and other stock-based awards to its employees.

Stock-Based Compensation Expense

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as expense over the requisite service period of the stock award (generally three to five years) using the straight-line method. The following table is a summary of stock-based compensation for the years ended December 31, 2021, 2020 and 2019:

In millions	**2021**	**2020**	**2019**
Stock options and stock appreciation rights ("SARs") [1]	$ 80	$ 71	$ 76
Restricted stock units and performance stock units	404	329	377
Total stock-based compensation	$ 484	$ 400	$ 453

(1) Includes the ESPP.

ESPP

The Company's Employee Stock Purchase Plan ("ESPP") provides for the purchase of up to 60 million shares of CVS Health Corporation common stock. Under the ESPP, eligible employees may purchase common stock at the end of each six month offering period at a purchase price equal to 90% of the lower of the fair market value on the first day or the last day of the offering period. During 2021, approximately 3 million shares of common stock were purchased under the provisions of the ESPP at an average price of $60.51 per share. As of December 31, 2021, approximately 31 million shares of common stock were available for issuance under the ESPP.

The fair value of stock-based compensation associated with the ESPP is estimated on the date of grant (the first day of the six month offering period) using the Black-Scholes option pricing model.

The following table is a summary of the assumptions used to value the ESPP awards for the years ended December 31, 2021, 2020 and 2019:

	2021	2020	2019
Dividend yield [1]	1.34 %	1.46 %	1.70 %
Expected volatility [2]	25.27 %	37.21 %	27.96 %
Risk-free interest rate [3]	0.08 %	0.81 %	2.27 %
Expected life (in years) [4]	0.5	0.5	0.5
Weighted-average grant date fair value	$ 12.55	$ 13.85	$ 10.51

(1) The dividend yield is calculated based on semi-annual dividends paid and the fair market value of CVS Health Corporation stock at the grant date.

(2) The expected volatility is estimated based on the historical volatility of CVS Health Corporation's daily stock price over the previous six month period.

(3) The risk-free interest rate is selected based on the Treasury constant maturity interest rate whose term is consistent with the expected term of ESPP purchases (i.e., six months).

(4) The expected life is based on the semi-annual purchase period.

Restricted Stock Units and Performance Stock Units

The Company's restricted stock units and performance stock units are considered nonvested share awards and require no payment from the employee. The fair value of the restricted stock units is based on the market price of CVS Health Corporation common stock on the grant date and is recognized on a straight-line basis over the vesting period. For each restricted stock unit granted, employees receive one share of common stock, net of taxes, at the end of the vesting period.

The Company's performance stock units contain performance vesting conditions in addition to a service vesting condition. Vesting of the Company's performance stock units is dependent upon the degree to which the Company achieves its performance goals, which are generally set for a three-year performance period and are approved at the time of grant by the MP&D Committee.

The fair value of performance stock units granted with service and performance vesting conditions is based on the market price of CVS Health Corporation common stock on the grant date and is recognized over the vesting period. Certain of the performance stock units also contain a market vesting condition based on the performance of CVS Health Corporation common stock relative to a comparator group. The fair value of these performance stock units is determined using a Monte Carlo simulation as of the grant date and is recognized over the vesting period.

As of December 31, 2021, there was $529 million of total unrecognized compensation cost related to the Company's restricted stock units and performance stock units that are expected to vest. These costs are expected to be recognized over a weighted-average period of 2.1 years. The total fair value of restricted stock units vested during 2021, 2020 and 2019 was $406 million, $229 million and $265 million, respectively.

The following table is a summary of the restricted stock unit and performance stock unit activity for the year ended December 31, 2021:

In thousands, except weighted average grant date fair value	Units	Weighted Average Grant Date Fair Value
Outstanding at beginning of year, nonvested	14,824	$ 58.12
Granted	6,190	$ 74.39
Vested	(5,448)	$ 74.47
Forfeited	(1,236)	$ 63.40
Outstanding at end of year, nonvested	14,330	$ 63.02

Stock Options and SARs

All stock option grants are awarded at fair value on the date of grant. The fair value of stock options is estimated using the Black-Scholes option pricing model, and stock-based compensation is recognized on a straight-line basis over the requisite

service period. Stock options granted generally become exercisable over a four-year period from the grant date. Stock options granted through 2018 generally expire seven years after the grant date. Stock options granted subsequent to 2018 generally expire ten years after the grant date.

All unvested Aetna SARs outstanding upon the acquisition of Aetna were converted into replacement CVS Health Corporation SARs. The replacement SARs granted are settled in CVS Health Corporation common stock, net of taxes, based on the appreciation of the stock price on the exercise date over the market price on the date of grant. The fair value of SARs is estimated using the Black-Scholes option pricing model, and stock-based compensation is recognized on a straight-line basis over the requisite service period. SARs generally become exercisable over a three-year period from the grant date. SARs generally expire ten years after the grant date. No SARs have been granted subsequent to the Aetna Acquisition.

The following table is a summary of stock option and SAR activity that occurred for the years ended December 31, 2021, 2020 and 2019:

In millions	**2021**	**2020**	**2019**
Cash received from stock options exercised (including ESPP)	$ 549	$ 264	$ 210
Payments for taxes for net share settlement of equity awards	168	88	112
Intrinsic value of stock options and SARs exercised	105	24	30
Fair value of stock options and SARs vested	224	252	467

The fair value of each stock option is estimated using the Black-Scholes option pricing model based on the following assumptions at the time of grant:

	2021	**2020**	**2019**
Dividend yield [1]	2.68 %	3.42 %	3.68 %
Expected volatility [2]	27.10 %	25.22 %	21.76 %
Risk-free interest rate [3]	1.13 %	0.61 %	0.56 %
Expected life (in years) [4]	6.3	6.3	6.3
Weighted-average grant date fair value	$ 14.57	$ 8.78	$ 6.27

(1) The dividend yield is based on annual dividends paid and the fair market value of CVS Health Corporation stock at the grant date.

(2) The expected volatility is estimated based on the historical volatility of CVS Health Corporation's daily stock price over a period equal to the expected life of each option grant after adjustments for infrequent events such as stock splits.

(3) The risk-free interest rate is selected based on yields from U.S. Treasury zero-coupon issues with a remaining term equal to the expected term of the options being valued.

(4) The expected life represents the number of years the options are expected to be outstanding from grant date based on historical option or SAR holder exercise experience.

As of December 31, 2021, unrecognized compensation expense related to unvested stock options totaled $38 million, which the Company expects to be recognized over a weighted-average period of 2.0 years. After considering anticipated forfeitures, the Company expects approximately 9 million of the unvested stock options to vest over the requisite service period.

The following table is a summary of the Company's stock option and SAR activity for the year ended December 31, 2021:

In thousands, except weighted average exercise price and remaining contractual term	Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term	Aggregate Intrinsic Value
Outstanding at beginning of year	23,955	$ 69.62		
Granted	3,322	$ 74.66		
Exercised	(6,366)	$ 63.41		
Forfeited	(694)	$ 62.66		
Expired	(1,156)	$ 87.42		
Outstanding at end of year	19,061	$ 71.74	4.75	$ 603,137
Exercisable at end of year	9,704	$ 79.99	2.61	229,034
Vested at end of year and expected to vest in the future	18,709	$ 71.82	4.69	590,514

12. Shareholders' Equity

Share Repurchases

The following share repurchase programs have been authorized by the Board:

In billions Authorization Date	Authorized	Remaining as of December 31, 2021
December 9, 2021 ("2021 Repurchase Program")	$ 10.0	$ 10.0
November 2, 2016 ("2016 Repurchase Program")	15.0	—

Each of the share Repurchase Programs was effective immediately. The 2016 Repurchase program was terminated effective December 9, 2021. The 2021 Repurchase Program permits the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase ("ASR") transactions, and/or other derivative transactions. The 2021 Repurchase Program can be modified or terminated by the Board at any time.

During the years ended December 31, 2021, 2020 and 2019, the Company did not repurchase any shares of common stock pursuant to the 2016 or 2021 Repurchase Programs.

Pursuant to the authorization under the 2021 Repurchase Program, the Company entered into a $1.5 billion fixed dollar ASR with Barclays Bank PLC ("Barclays"). Upon payment of the $1.5 billion purchase price on January 4, 2022, the Company received a number of shares of CVS Health Corporation's common stock equal to 80% of the $1.5 billion notional amount of the ASR or approximately 11.6 million shares at a price of $103.34 per share, which were placed into treasury stock in January 2022. At the conclusion of the ASR, the Company may receive additional shares equal to the remaining 20% of the $1.5 billion notional amount. The ultimate number of shares the Company may receive will depend on the daily volume-weighted average price of the Company's stock over an averaging period, less a discount. It is also possible, depending on such weighted average price, that the Company will have an obligation to Barclays which, at the Company's option, could be settled in additional cash or by issuing shares. Under the terms of the ASR, the maximum number of shares that could be delivered to the Company is 29.0 million.

Dividends

The quarterly cash dividend declared by the Board was $0.50 per share in 2021 and 2020. In December 2021, the Board authorized a 10% increase in the quarterly cash dividend to $0.55 per share effective in 2022. CVS Health Corporation has paid cash dividends every quarter since becoming a public company. Future dividend payments will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

Regulatory Requirements

The Company's insurance business operations are conducted through subsidiaries that principally consist of health maintenance organizations ("HMOs") and insurance companies. The Company's HMO and insurance subsidiaries report their financial

statements in accordance with accounting practices prescribed by state regulatory authorities which may differ from GAAP. The combined statutory net income for the years ended and estimated combined statutory and capital surplus at December 31, 2021, 2020 and 2019 for the Company's insurance and HMO subsidiaries were as follows:

In millions	**2021**	**2020**	**2019**
Statutory net income	$ 3,302	$ 3,667	$ 2,842
Estimated statutory capital and surplus	14,879	13,238	10,975

The Company's insurance and HMO subsidiaries paid $1.6 billion of gross dividends to the Company for the year ended December 31, 2021.

In addition to general state law restrictions on payments of dividends and other distributions to stockholders applicable to all corporations, HMOs and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity and restrict the amount of dividends and other distributions that may be paid to their equity holders. In addition, in connection with the Aetna Acquisition, the Company made certain undertakings that require prior regulatory approval of dividends by certain of its HMOs and insurance companies. At December 31, 2021, these amounts were as follows:

In millions	
Estimated minimum statutory surplus required by regulators	$ 7,261
Investments on deposit with regulatory bodies	794
Estimated maximum dividend distributions permitted in 2022 without prior regulatory approval	2,939

Noncontrolling Interests

At December 31, 2021 and 2020, noncontrolling interests were $306 million and $312 million, respectively, primarily related to third party interests in the Company's operating entities. The noncontrolling entities' share is included in total shareholders' equity on the consolidated balance sheets.

13. Other Comprehensive Income

Shareholders' equity included the following activity in accumulated other comprehensive income in 2021, 2020 and 2019:

	At December 31,		
In millions	**2021**	**2020**	**2019**
Net unrealized investment gains (losses):			
Beginning of year balance	$ 1,214	$ 774	$ 97
Other comprehensive income (loss) before reclassifications *($(489), $497 and $927 pretax)*	(410)	415	763
Amounts reclassified from accumulated other comprehensive income *($(32), $31 and $(105) pretax)* [(1)]	(26)	25	(86)
Other comprehensive income (loss)	(436)	440	677
End of year balance	778	1,214	774
Foreign currency translation adjustments:			
Beginning of year balance	7	4	(158)
Other comprehensive income (loss) before reclassifications	(7)	3	8
Amounts reclassified from accumulated other comprehensive income (loss) [(2)]	—	—	154
Other comprehensive income (loss)	(7)	3	162
End of year balance	—	7	4
Net cash flow hedges:			
Beginning of year balance	248	279	312
Other comprehensive loss before reclassifications *($0, $(7) and $(25) pretax)*	—	(5)	(18)
Amounts reclassified from accumulated other comprehensive income *($(34), $(35) and $(20) pretax)* [(3)]	(26)	(26)	(15)
Other comprehensive loss	(26)	(31)	(33)
End of year balance	222	248	279
Pension and other postretirement benefits:			
Beginning of year balance	(55)	(38)	(149)
Other comprehensive income (loss) before reclassifications *($20, $(30) and $162 pretax)*	15	(22)	120
Amounts reclassified from accumulated other comprehensive loss *($6, $7 and $(12) pretax)* [(4)]	5	5	(9)
Other comprehensive income (loss)	20	(17)	111
End of year balance	(35)	(55)	(38)
Total beginning of year accumulated other comprehensive income	1,414	1,019	102
Total other comprehensive income (loss)	(449)	395	917
Total end of year accumulated other comprehensive income	$ 965	$ 1,414	$ 1,019

(1) Amounts reclassified from accumulated other comprehensive income for specifically identified debt securities are included in net investment income in the consolidated statements of operations.

(2) Amounts reclassified from accumulated other comprehensive income (loss) represent the elimination of the cumulative translation adjustment associated with the sale of Onofre, which was sold on July 1, 2019. The loss on the divestiture of Onofre is reflected in operating expenses in the consolidated statements of operations.

(3) Amounts reclassified from accumulated other comprehensive income for specifically identified cash flow hedges are included within interest expense in the consolidated statements of operations. The Company expects to reclassify approximately $11 million, net of tax, in net gains associated with its cash flow hedges into net income within the next 12 months.

(4) Amounts reclassified from accumulated other comprehensive loss for specifically identified pension and other postretirement benefits are included in other income in the consolidated statements of operations.

14. Earnings Per Share

Earnings per share is computed using the two-class method. SARs and options to purchase 7 million, 15 million, and 17 million shares of common stock were outstanding, but were excluded from the calculation of diluted earnings per share for the years ended December 31, 2021, 2020 and 2019, respectively, because their exercise prices were greater than the average market price of the common shares and, therefore, the effect would be antidilutive.

The following is a reconciliation of basic and diluted earnings per share from continuing operations for the years ended December 31, 2021, 2020 and 2019:

In millions, except per share amounts	**2021**	**2020**	**2019**
Numerator for earnings per share calculation:			
Income from continuing operations	$ 7,898	$ 7,201	$ 6,631
Income allocated to participating securities	—	—	(5)
Net (income) loss attributable to noncontrolling interests	12	(13)	3
Income from continuing operations attributable to CVS Health	$ 7,910	$ 7,188	$ 6,629
Denominator for earnings per share calculation:			
Weighted average shares, basic	1,319	1,309	1,301
Effect of dilutive securities	10	5	4
Weighted average shares, diluted	1,329	1,314	1,305
Earnings per share from continuing operations:			
Basic	$ 6.00	$ 5.49	$ 5.10
Diluted	$ 5.95	$ 5.47	$ 5.08

15. Reinsurance

The Company utilizes reinsurance agreements primarily to: (a) reduce required capital and (b) facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit the Company to recover a portion of its losses from reinsurers, although they do not discharge the Company's primary liability as the direct insurer of the risks reinsured.

On November 30, 2018, the Company completed the sale of Aetna's standalone Medicare Part D prescription drug plans to a subsidiary of WellCare Health Plans, Inc. ("WellCare"), effective December 31, 2018. In connection with that sale, subsidiaries of WellCare and Aetna entered into reinsurance agreements under which WellCare ceded to Aetna 100% of the insurance risk related to the divested standalone Medicare Part D prescription drug plans for the 2019 PDP plan year.

In January 2022, the Company entered into two four-year reinsurance agreements with an unrelated reinsurer that allow it to reduce required capital and provide collateralized excess of loss reinsurance coverage on a portion of the Health Care Benefits segment's group Commercial Insured business.

Reinsurance recoverables (recorded as other current assets or other assets on the consolidated balance sheets) at December 31, 2021 and 2020 were as follows:

In millions	2021	2020
Reinsurer		
Hartford Life and Accident Insurance Company	$ 1,887	$ 2,364
Lincoln Life & Annuity Company of New York	395	406
VOYA Retirement Insurance and Annuity Company	167	170
All Other	100	115
Total	$ 2,549	$ 3,055

Direct, assumed and ceded premiums earned for the years ended December 31, 2021, 2020 and 2019 were as follows:

In millions	**2021**	**2020**	**2019**
Direct	$ 76,320	$ 69,711	$ 62,968
Assumed	492	478	2,108
Ceded	(680)	(825)	(1,954)
Net premiums	$ 76,132	$ 69,364	$ 63,122

The impact of reinsurance on benefit costs for the years ended December 31, 2021, 2020 and 2019 were as follows:

In millions	**2021**	**2020**	**2019**
Direct	$ 64,414	$ 56,077	$ 52,592
Assumed	398	329	1,562
Ceded	(552)	(727)	(1,625)
Net benefit costs	$ 64,260	$ 55,679	$ 52,529

There is not a material difference between premiums on a written basis versus an earned basis.

The Company also has various agreements with unrelated reinsurers that do not qualify for reinsurance accounting under GAAP, and consequently are accounted for using deposit accounting. The Company entered into these contracts to reduce the risk of catastrophic loss which in turn reduces the Company's capital and surplus requirements. Total deposit assets and liabilities related to reinsurance agreements that do not qualify for reinsurance accounting under GAAP were not material as of December 31, 2021 or 2020.

16. Commitments and Contingencies

COVID-19

The COVID-19 pandemic continues to evolve. The Company believes COVID-19's impact on its businesses, operating results, cash flows and/or financial condition primarily will be driven by the geographies impacted and the severity and duration of the pandemic; the pandemic's impact on the U.S. and global economies and consumer behavior and health care utilization patterns; and the timing, scope and impact of stimulus legislation as well as other federal, state and local governmental responses to the pandemic. Those primary drivers are beyond the Company's knowledge and control. As a result, the impact COVID-19 will have on the Company's businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be adverse and material. COVID-19 also may result in legal and regulatory proceedings, investigations and claims against the Company.

Guarantees

The Company has the following significant guarantee arrangements at December 31, 2021:

- ASC Claim Funding Accounts - The Company has arrangements with certain banks for the processing of claim payments for its ASC customers. The banks maintain accounts to fund claims of the Company's ASC customers. The customer is responsible for funding the amount paid by the bank each day. In these arrangements, the Company guarantees that the banks will not sustain losses if the responsible ASC customer does not properly fund its account. The aggregate maximum exposure under these arrangements is generally limited to $250 million. The Company can limit its exposure to these guarantees by suspending the payment of claims for ASC customers that have not adequately funded the amount paid by the bank.
- Separate Accounts Assets - Certain Separate Accounts assets associated with the large case pensions business in the Corporate/Other segment represent funds maintained as a contractual requirement to fund specific pension annuities that the Company has guaranteed. Minimum contractual obligations underlying the guaranteed benefits in these Separate Accounts were approximately $1.3 billion and $1.4 billion at December 31, 2021 and 2020, respectively. See Note 1 "Significant Accounting Policies" for additional information on Separate Accounts.

Contract holders assume all investment and mortality risk and are required to maintain Separate Accounts balances at or above a specified level. The level of required funds is a function of the risk underlying the Separate Account's investment strategy. If contract holders do not maintain the required level of Separate Accounts assets to meet the annuity guarantees, the Company would

establish an additional liability. Contract holders' balances in the Separate Accounts at December 31, 2021 exceeded the value of the guaranteed benefit obligation. As a result, the Company was not required to maintain any additional liability for its related guarantees at December 31, 2021.

Lease Guarantees

Between 1995 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores and Linens 'n Things, each of which subsequently filed for bankruptcy, and Marshalls. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the former subsidiary's lease obligations for the initial lease term and any extension thereof pursuant to a renewal option provided for in the lease prior to the time of the disposition. When the subsidiaries were disposed of and accounted for as discontinued operations, the Company's guarantees remained in place, although each initial purchaser agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries fail to make the required payments under a store lease, the Company could be required to satisfy those obligations, and any significant adverse impact of COVID-19 on such purchasers and/or former subsidiaries increases the risk that the Company will be required to satisfy those obligations. As of December 31, 2021, the Company guaranteed 72 such store leases (excluding the lease guarantees related to Linens 'n Things, which have been recorded as a liability on the consolidated balance sheets), with the maximum remaining lease term extending through 2030.

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers and life insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. The Company has recorded a liability for its estimated share of future assessments by applicable life and health insurance guaranty associations. It is reasonably possible that in the future the Company may record a liability and expense relating to other insolvencies which could have a material adverse effect on the Company's operating results, financial condition and cash flows, and the risk is heightened by any significant adverse impact of the COVID-19 pandemic on the solvency of other insurers, including long-term care and life insurers. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that limit future offsets.

HMOs in certain states in which the Company does business are subject to assessments, including market stabilization and other risk-sharing pools, for which the Company is assessed charges based on incurred claims, demographic membership mix and other factors. The Company establishes liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments the Company pays are dependent upon the Company's experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, the Company believes it has adequate reserves to cover such assessments.

The Company's total guaranty fund assessments liability was immaterial at both December 31, 2021 and 2020.

Litigation and Regulatory Proceedings

The Company has been involved or is currently involved in numerous legal proceedings, including litigation, arbitration, government investigations, audits, reviews and claims. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, the U.S. Department

of Justice (the “DOJ”), state attorneys general, the U.S. Drug Enforcement Administration (the “DEA”) and other governmental authorities.

Legal proceedings, in general, and securities, class action and multi-district litigation, in particular, and governmental special investigations, audits and reviews can be expensive and disruptive. Some of the litigation matters may purport or be determined

to be class actions and/or involve parties seeking large and/or indeterminate amounts, including punitive or exemplary damages, and may remain unresolved for several years. The Company also may be named from time to time in *qui tam* actions initiated by private third parties that could also be separately pursued by a governmental body. The results of legal proceedings, including government investigations, are often uncertain and difficult to predict, and the costs incurred in these matters can be substantial, regardless of the outcome.

The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and reasonably estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial condition.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. The Company believes that its defenses and assertions in pending legal proceedings have merit and does not believe that any of these pending matters, after consideration of applicable reserves and rights to indemnification, will have a material adverse effect on the Company's financial position. Substantial unanticipated verdicts, fines and rulings, however, do sometimes occur, which could result in judgments against the Company, entry into settlements or a revision to its expectations regarding the outcome of certain matters, and such developments could have a material adverse effect on its results of operations. In addition, as a result of governmental investigations or proceedings, the Company may be subject to damages, civil or criminal fines or penalties, or other sanctions including possible suspension or loss of licensure and/or exclusion from participating in government programs. The outcome of such governmental investigations of proceedings could be material to the Company.

Usual and Customary Pricing Litigation

The Company and certain current and former directors and officers are named as a defendant in a number of lawsuits that allege that the Company's retail pharmacies overcharged for prescription drugs by not submitting the correct usual and customary price during the claims adjudication process. These actions are brought by a number of different types of plaintiffs, including plan members, private payors, government payors, and shareholders based on different legal theories. Some of these cases are brought as putative class actions, and in some instances, classes have been certified. The Company is defending itself against these claims.

PBM Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning its PBM practices.

The Company is facing multiple lawsuits, including by a State Attorney General, governmental subdivisions and several putative class actions, regarding drug pricing and its rebate arrangements with drug manufacturers. These complaints, brought by a number of different types of plaintiffs under a variety of legal theories, generally allege that rebate agreements between the drug manufacturers and PBMs caused inflated prices for certain drug products. The Company is defending itself against these claims. The Company has also received subpoenas, civil investigative demands ("CIDs") and other requests for documents and information from, and is being investigated by, Attorneys General of multiple states and the District of Columbia regarding its PBM practices, including pricing and rebates. The Company has been providing documents and information in response to these subpoenas, CIDs and requests for information.

United States ex rel. Behnke v. CVS Caremark Corporation, et al. (U.S. District Court for the Eastern District of Pennsylvania). In April 2018, the Court unsealed a complaint filed in February 2014. The government has declined to intervene in this case. The relator alleges that the Company submitted, or caused to be submitted, to Part D of the Medicare program Prescription Drug Event data and/or Direct and Indirect Remuneration reports that misrepresented true prices paid by the Company's PBM to pharmacies for drugs dispensed to Part D beneficiaries with prescription benefits administered by the Company's PBM. The Company is defending itself against these claims.

Controlled Substances Litigation, Audits and Subpoenas

In December 2017, the U.S. Judicial Panel on Multidistrict Litigation consolidated numerous cases filed against various defendants by plaintiffs such as counties, cities, hospitals, Indian tribes and third-party payors, alleging claims generally concerning the impacts of widespread prescription opioid abuse. The consolidated multidistrict litigation captioned In re National Prescription Opiate Litigation (MDL No. 2804) is pending in the U.S. District Court for the Northern District of Ohio. This multidistrict litigation presumptively includes hundreds of relevant federal court cases that name the Company as a defendant. A significant number of similar cases that name the Company as a defendant in some capacity are pending in state courts. In addition, the Company has been named as a defendant in similar cases brought by certain state Attorneys General. The Company is defending itself against all such claims. Additionally, the Company has received subpoenas, CIDs and/or other requests for information regarding opioids from state Attorneys General and insurance and other regulators of several U.S. jurisdictions. The Company has been cooperating with the government with respect to these subpoenas, CIDs and other requests for information. In November 2021, the Company was among the chain pharmacies found liable by a jury in a trial in federal court in Ohio; the remedy pursuant to that verdict has not been determined and the Company plans to appeal.

In January 2020, the DOJ served the Company with a DEA administrative subpoena. The subpoena seeks documents relating to practices with respect to prescription opioids and other controlled substances at CVS Pharmacy locations concerning potential violations of the federal Controlled Substances Act and the federal False Claims Act. In January 2022, the DOJ served the Company with a CID regarding similar subjects. The Company is providing documents and information in response to these matters.

Prescription Processing Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning its prescription processing practices, including the following:

U.S. ex rel. *Bassan* et al. *v. Omnicare, Inc. and CVS Health Corp.* (U.S. District Court for the Southern District of New York). In December 2019, the U.S. Attorney's Office for the Southern District of New York (the "SDNY") filed a complaint-in-intervention in this previously sealed *qui tam* case. The complaint alleges that for certain non-skilled nursing facilities, Omnicare improperly filled prescriptions beyond one year where a valid prescription did not exist and that these dispensing events violated the federal False Claims Act. The Company is defending itself against these claims.

In July 2017, the Company also received a subpoena from the California Department of Insurance requesting documents concerning the Company's Omnicare pharmacies' cycle fill process for assisted living facilities. The Company has been cooperating with the California Department of Insurance and providing documents and information in response to this subpoena.

In December 2016, the Company received a CID from the U.S. Attorney's Office for the Northern District of New York requesting documents and information in connection with a federal False Claims Act investigation concerning whether the Company's retail pharmacies improperly submitted certain insulin claims to Part D of the Medicare program rather than Part B of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to this CID.

Provider Proceedings

The Company is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by providers with whom the Company has a contract and with whom the Company does not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that the Company paid too little to its health plan members and/or providers for out-of-network services and/or otherwise allege that the Company failed to timely or appropriately pay or administer out-of-network claims and benefits (including the Company's post payment audit and collection practices and reductions in payments to providers due to sequestration). Other major health insurers are the subject of similar litigation or have settled similar litigation.

The Company also has received subpoenas and/or requests for documents and other information from, and been investigated by, state Attorneys General and other state and/or federal regulators, legislators and agencies relating to, and the Company is involved in other litigation regarding, its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against the Company with respect to its out-of-network benefit payment and/or administration practices.

CMS Actions

CMS regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to the Company's and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by providers. The Company collects claim and encounter data from providers and generally relies on providers to appropriately code their submissions to the Company and document their medical records, including the diagnosis data submitted to the Company with claims. CMS pays increased premiums to Medicare Advantage plans and Medicare PDP plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to the Company. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by providers and the resulting risk adjusted premium payments to the plans. CMS may require the Company to refund premium payments if the Company's risk adjusted premiums are not properly supported by medical record data. The Office of the Inspector General of the HHS (the "OIG") also is auditing the Company's risk adjustment-related data and that of other companies. The Company expects CMS and the OIG to continue these types of audits.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will extrapolate the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. For contract years prior to 2011, CMS did not extrapolate sample error rates to the entire contract. As a result, the revised methodology may increase the Company's exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various contract years for RADV audit, and the number of RADV audits continues to increase. The Company is currently unable to predict which of its Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to the Company, the effect of any such refunds or adjustments on the actuarial soundness of the Company's Medicare Advantage bids, or whether any RADV audit findings would require the Company to change its method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in the Company's bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG or otherwise, including audits of the Company's MLR rebates, methodology and/or reports, could be material and could adversely affect the Company's operating results, cash flows and/or financial condition.

Medicare and Medicaid CIDs

The Company has received CIDs from the Civil Division of the DOJ in connection with a current investigation of the Company's patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

In May 2017, the Company received a CID from the SDNY requesting documents and information concerning possible false claims submitted to Medicare in connection with reimbursements for prescription drugs under the Medicare Part D program. The Company has been cooperating with the government and providing documents and information in response to this CID.

Stockholder Matters

Beginning in February 2019, multiple class action complaints, as well as a derivative complaint, were filed by putative plaintiffs against the Company and certain current and former officers and directors. The plaintiffs in these cases assert a variety of causes of action under federal securities laws that are premised on allegations that the defendants made certain omissions and misrepresentations relating to the performance of the Company's LTC

business unit. The Company and its current and former officers and directors are defending themselves against these claims. Since filing, several of the cases have been consolidated, and the first-filed federal case, *City of Miami Fire Fighters' and Police Officers' Retirement Trust,* et al. (formerly known as *Anarkat*), was dismissed with prejudice in February 2021. Plaintiffs have appealed that decision to the First Circuit after their motion for reconsideration was denied. *In re CVS Health Corp. Securities Act Litigation* (formerly known as *Waterford*) and *In*

re CVS Health Corp. Securities Litigation (formerly known as *City of Warren* and *Freundlich*) have been stayed pending the outcome of the First Circuit appeal.

In August and September 2020, two class actions under the Employee Retirement Income Security Act of 1974 ("ERISA") were filed in the U.S. District Court for the District of Connecticut against CVS Health, Aetna, and several current and former executives, directors and/or members of Aetna's Compensation and Talent Management Committee: *Radcliffe v. Aetna Inc.,* et al. and *Flaim v. Aetna Inc.,* et al. The plaintiffs in these cases assert a variety of causes of action premised on allegations that the defendants breached fiduciary duties and engaged in prohibited transactions relating to participants in the Aetna 401(k) Plan's investment in company stock between December 3, 2017 and February 20, 2019, claiming losses related to the performance of the Company's LTC business unit. The district court consolidated the actions and the Company is defending itself against these claims. In October 2021, the consolidated case was dismissed without prejudice. Plaintiffs may seek leave to file an amended complaint. The Company also received a related document request pursuant to ERISA § 104(b), to which the Company has responded.

In December 2021, the Company received a demand for inspection of books and records pursuant to Delaware Corporation Law Section 220 (the "Demand"). The Demand purports to be related to potential breaches of fiduciary duties by the Board in relation to certain matters concerning opioids.

Other Legal and Regulatory Proceedings

The Company is also a party to other legal proceedings and is subject to government investigations, inquiries and audits and has received and is cooperating with the government in response to CIDs, subpoenas or similar process from various governmental agencies requesting information. These other legal proceedings and government actions include claims of or relating to bad faith, medical or professional malpractice, breach of fiduciary duty, claims processing, dispensing of medications, non-compliance with state and federal regulatory regimes, marketing misconduct, denial of or failure to timely or appropriately pay or administer claims and benefits, provider network structure (including the use of performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure or use of personal information, anticompetitive practices, general contractual matters, product liability, intellectual property litigation and employment litigation. Some of these other legal proceedings are or are purported to be class actions or derivative claims. The Company is defending itself against the claims brought in these matters.

Awards to the Company and others of certain government contracts, particularly Medicaid contracts and other contracts with government customers in the Company's Health Care Benefits segment, frequently are subject to protests by unsuccessful bidders. These protests may result in awards to the Company being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect the Company's operating results. The Company will continue to defend contract awards it receives.

There also continues to be a heightened level of review and/or audit by regulatory authorities and legislators of, and increased litigation regarding, the Company's and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including manufacturers' rebates, pricing, the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health solutions company, the Company regularly is the subject of government actions of the types described above. These government actions may prevent or delay the Company from implementing planned premium rate increases and may result, and have resulted, in restrictions on the Company's businesses, changes to or clarifications of the Company's business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to the Company by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

The Company can give no assurance that its businesses, financial condition, operating results and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or

regulations as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state government investigations of one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

17. Segment Reporting

The Company has three operating segments, Health Care Benefits, Pharmacy Services and Retail/LTC, as well as a Corporate/Other segment. The Company's segments maintain separate financial information, and the Company's chief operating decision maker (the "CODM") evaluates the segments' operating results on a regular basis in deciding how to allocate resources among the segments and in assessing segment performance. The CODM evaluates the performance of the Company's segments based on adjusted operating income, which is defined as operating income (GAAP measure) excluding the impact of amortization of intangible assets and other items, if any, that neither relate to the ordinary course of the Company's business nor reflect the Company's underlying business performance. See the reconciliation of consolidated operating income (GAAP measure) to consolidated adjusted operating income below for further context regarding the items excluded from operating income in determining adjusted operating income. The Company uses adjusted operating income as its principal measure of segment performance as it enhances the Company's ability to compare past financial performance with current performance and analyze underlying business performance and trends. Non-GAAP financial measures the Company discloses, such as consolidated adjusted operating income, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

In 2021, 2020 and 2019, revenues from the federal government accounted for 17%, 16% and 16%, respectively, of the Company's consolidated total revenues, primarily related to contracts with CMS for coverage of Medicare-eligible individuals within the Health Care Benefits segment.

The following is a reconciliation of financial measures of the Company's segments to the consolidated totals:

In millions	Health Care Benefits	Pharmacy Services [1]	Retail/ LTC	Corporate/ Other	Intersegment Eliminations [2]	Consolidated Totals
2021:						
Revenues from external customers	$ 81,515	$ 143,194	$ 66,078	$ 125	$ —	$ 290,912
Intersegment revenues	85	9,828	34,010	—	(43,923)	—
Net investment income	586	—	17	596	—	1,199
Total revenues	82,186	153,022	100,105	721	(43,923)	292,111
Adjusted operating income (loss)	5,012	6,859	7,623	(1,471)	(711)	17,312
Depreciation and amortization	1,837	576	1,884	215	—	4,512
2020:						
Revenues from external customers	74,926	132,663	60,208	111	—	267,908
Intersegment revenues	58	9,275	30,990	—	(40,323)	—
Net investment income	483	—	—	315	—	798
Total revenues	75,467	141,938	91,198	426	(40,323)	268,706
Adjusted operating income (loss)	6,188	5,688	6,146	(1,306)	(708)	16,008
Depreciation and amortization	1,832	612	1,801	196	—	4,441
2019:						
Revenues from external customers	68,979	130,428	56,258	100	—	255,765
Intersegment revenues	26	11,063	30,350	—	(41,439)	—
Net investment income	599	—	—	412	—	1,011
Total revenues	69,604	141,491	86,608	512	(41,439)	256,776
Adjusted operating income (loss)	5,202	5,129	6,705	(1,000)	(697)	15,339
Depreciation and amortization	1,721	766	1,723	161	—	4,371

(1) Total revenues of the Pharmacy Services segment include approximately $11.6 billion, $10.9 billion and $11.5 billion of retail co-payments for 2021, 2020 and 2019, respectively. See Note 1 "Significant Accounting Policies" for additional information about retail co-payments.

(2) Intersegment revenue eliminations relate to intersegment revenue generating activities that occur between the Health Care Benefits segment, the Pharmacy Services segment, and/or the Retail/LTC segment. Intersegment adjusted operating income eliminations occur when members of Pharmacy Services Segment clients ("PSS members") enrolled in Maintenance Choice® elect to pick up maintenance prescriptions at one of the Company's retail pharmacies instead of receiving them through the mail. When this occurs, both the Pharmacy Services and Retail/LTC segments record the adjusted operating income on a stand-alone basis.

The following is a reconciliation of consolidated operating income to adjusted operating income for the years ended December 31, 2021, 2020 and 2019:

In millions	**2021**	**2020**	**2019**
Operating income (GAAP measure)	$ 13,193	$ 13,911	$ 11,987
Amortization of intangible assets [(1)]	2,259	2,341	2,436
Acquisition-related integration costs [(2)]	132	332	480
Store impairments [(3)]	1,358	—	231
Goodwill impairment [(4)]	431	—	—
Acquisition purchase price adjustment outside of measurement period [(5)]	(61)	—	—
(Gain) loss on divestiture of subsidiary [(6)]	—	(269)	205
Receipt of fully reserved ACA risk corridor receivable [(7)]	—	(307)	—
Adjusted operating income	$ 17,312	$ 16,008	$ 15,339

(1) The Company's acquisition activities have resulted in the recognition of intangible assets as required under the acquisition method of accounting which consist primarily of trademarks, customer contracts/relationships, covenants not to compete, technology, provider networks and value of business acquired. Definite-lived intangible assets are amortized over their estimated useful lives and are tested for impairment when events indicate that the carrying value may not be recoverable. The amortization of intangible assets is reflected in the Company's GAAP consolidated statements of operations in operating expenses within each segment. Although intangible assets contribute to the Company's revenue generation, the amortization of intangible assets does not directly relate to the underwriting of the Company's insurance products, the services performed for the Company's customers or the sale of the Company's products or services. Additionally, intangible asset amortization expense typically fluctuates based on the size and timing of the Company's acquisition activity. Accordingly, the Company believes excluding the amortization of intangible assets enhances the Company's and investors' ability to compare the Company's past financial performance with its current performance and to analyze underlying business performance and trends. Intangible asset amortization excluded from the related non-GAAP financial measure represents the entire amount recorded within the Company's GAAP financial statements, and the revenue generated by the associated intangible assets has not been excluded from the related non-GAAP financial measure. Intangible asset amortization is excluded from the related non-GAAP financial measure because the amortization, unlike the related revenue, is not affected by operations of any particular period unless an intangible asset becomes impaired or the estimated useful life of an intangible asset is revised.

(2) In 2021, 2020 and 2019, acquisition-related integration costs relate to the Aetna Acquisition. The acquisition-related integration costs are reflected in the Company's GAAP consolidated statements of operations in operating expenses within the Corporate/Other segment.

(3) During the year ended December 31, 2021, the store impairment charge relates to the write down of operating lease right-of-use assets and property and equipment in connection with the planned closure of approximately 900 retail stores between 2022 and 2024. During the year ended December 31, 2019, the store impairment charges related to the write down of operating lease right-of-use assets in connection with the planned closure of 68 underperforming retail pharmacy stores in 2019 and 2020. The store impairment charges are reflected in the Company's GAAP consolidated statements of operations within the Retail/LTC segment.

(4) During the year ended December 31, 2021, the goodwill impairment charge relates to the LTC reporting unit within the Retail/LTC segment.

(5) In June 2021, the Company received $61 million related to a purchase price working capital adjustment for an acquisition completed during the first quarter of 2020. The resolution of this matter occurred subsequent to the acquisition accounting measurement period and is reflected in the Company's GAAP consolidated statement of operations for the year ended December 31, 2021 as a reduction of operating expenses within the Health Care Benefits segment.

(6) In 2020, the gain on divestiture of subsidiary represents the pre-tax gain on the sale of the Workers' Compensation business, which the Company sold on July 31, 2020 for approximately $850 million. The gain on divestiture is reflected as a reduction of operating expenses in the Company's GAAP consolidated statement of operations within the Health Care Benefits segment. In 2019, the loss on divestiture of subsidiary represents the pre-tax loss on the sale of Onofre, which occurred on July 1, 2019. The loss on divestiture primarily relates to the elimination of the cumulative translation adjustment from accumulated other comprehensive income and is reflected in the Company's GAAP consolidated statement of operations in operating expenses within the Retail/LTC segment.

(7) In 2020, the Company received $313 million owed to it under the ACA's risk corridor program that was previously fully reserved for as payment was uncertain. After considering offsetting items such as the ACA's minimum MLR rebate requirements and premium taxes, the Company recognized pre-tax income of $307 million in the Company's GAAP consolidated statement of operations within the Health Care Benefits segment.

Index to Consolidated Financial Statements

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of CVS Health Corporation

Opinion on Internal Control over Financial Reporting

We have audited CVS Health Corporation's internal control over financial reporting as of December 31, 2021, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, CVS Health Corporation (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2021, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the 2021 consolidated financial statements of the Company and our report dated February 9, 2022, expressed an unqualified opinion thereon.

Basis for Opinion

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

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

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

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ Ernst & Young LLP

Boston, Massachusetts
February 9, 2022

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of CVS Health Corporation

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of CVS Health Corporation (the Company) as of December 31, 2021 and 2020, the related consolidated statements of operations, comprehensive income, shareholders' equity and cash flows for each of the three years in the period ended December 31, 2021, and the related notes (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2021 and 2020, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2021, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2021, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated February 9, 2022, expressed an unqualified opinion thereon.

Basis for Opinion

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

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

Critical Audit Matters

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

Annual goodwill impairment test of the Commercial Business reporting unit

Description of the Matter

At December 31, 2021, the Company's goodwill related to the Commercial Business reporting unit was $26.5 billion. As discussed in Note 1 to the consolidated financial statements, goodwill is not amortized, but rather is subject to an annual impairment review, or more frequent reviews, if events and circumstances indicate an impairment exists.

Auditing management's annual goodwill impairment test related to the Commercial Business reporting unit was complex and highly judgmental due to the significant estimation required to determine the fair value of the reporting unit. In particular, the fair value estimate was sensitive to changes in significant assumptions, such as the discount rate, projected revenue and projected operating income that are forward-looking and affected by future economic and market conditions.

How We Addressed the Matter in Our Audit

We obtained an understanding, evaluated the design and tested the operating effectiveness of controls over the Company's annual goodwill impairment review process, including controls over management's review of the significant assumptions described above.

To test the estimated fair value of the Commercial Business reporting unit, we performed audit procedures that included, among others, assessing methodologies and testing the significant assumptions discussed above and the underlying data used by the Company in its analysis. We compared the significant assumptions to the reporting unit's historical results and third-party industry data. We performed sensitivity analyses of significant assumptions to evaluate the changes in the fair value of the reporting unit that would result from changes in the key assumptions. We involved valuation specialists to assist in our assessment of the methodology and significant assumptions (such as the discount rate) used by the Company. In addition, we tested management's reconciliation of the fair value of all reporting units to the market capitalization of the Company.

Valuation of health care costs payable

Description of the Matter

At December 31, 2021, the incurred but not reported ("IBNR") liabilities represented $6.6 billion of $8.8 billion of health care costs payable. As discussed in Note 1 to the consolidated financial statements, the Company's liability for health care costs payable includes estimated payments for (1) services rendered to members but not yet reported and (2) claims that have been reported but not yet paid, each as of the financial statement date (collectively, "IBNR"). The estimated IBNR liability is developed utilizing actuarial principles and assumptions that include historical and projected claim submission and processing patterns, historical and assumed medical cost trends, historical utilization of medical services, claim inventory levels, changes in membership and product mix, seasonality and other relevant factors to record the actuarial best estimate of health care costs payable. There is significant uncertainty inherent in determining management's actuarial best estimate of health care costs payable. In particular, the estimate is sensitive to the assumed completion factors and the assumed health care cost trend rates.

Auditing management's actuarial best estimate of IBNR reserves for health care costs payable for its products and services involved a high degree of subjectivity in evaluating management's assumptions used in the valuation process.

How We Addressed the Matter in Our Audit

We obtained an understanding, evaluated the design and tested the operating effectiveness of controls over the process for estimating IBNR reserves. This included, among others, controls over the completeness and accuracy of data used in the actuarial projections, the transfer of data between underlying source systems, and the review and approval processes that management has in place for the actuarial principles and assumptions used in estimating the health care costs payable.

To test IBNR reserves, our audit procedures included, among others, testing the completeness and accuracy of the underlying claim and membership data used in the calculation of IBNR reserves. We involved actuarial specialists to assist with our audit procedures, which included, among others, evaluating the methodologies applied by the Company in determining the actuarially determined liability, evaluating management's actuarial principles and assumptions used in their analysis based on historical claim experience, and independently calculating a range of reserve estimates for comparison to management's actuarial best estimate of the liability for health care costs payable. Additionally, we performed a review of the prior period liabilities for incurred but not paid claims to subsequent claims development.

/s/ Ernst & Young LLP

We have served as the Company's auditor since 2007.

Boston, Massachusetts
February 9, 2022

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

None.

Item 9A. Controls and Procedures.

Evaluation of disclosure controls and procedures

The Company's Chief Executive Officer and Chief Financial Officer, after evaluating the effectiveness of the design and operation of the Company's disclosure controls and procedures (as defined in Rules 13a-15 (f) and 15d-15(f) under the Securities Exchange Act of 1934) as of December 31, 2021, have concluded that as of such date the Company's disclosure controls and procedures were adequate and effective at a reasonable assurance level and designed to ensure that material information relating to the Company and its consolidated subsidiaries would be made known to such officers on a timely basis.

Management's report on internal control over financial reporting

Management is responsible for establishing and maintaining adequate internal control over financial reporting. The Company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of the Company's consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the Company's assets that could have a material effect on the Company's consolidated financial statements. In order to ensure the Company's internal control over financial reporting is effective, management regularly assesses such control and did so most recently for its financial reporting as of December 31, 2021.

Management conducted an assessment of the effectiveness of the Company's internal control over financial reporting based on the criteria established in *Internal Control-Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 Framework). This evaluation included review of the documentation, evaluation of the design effectiveness and testing of the operating effectiveness of controls. The Company's system of internal control over financial reporting is enhanced by periodic reviews by the Company's internal auditors, written policies and procedures and a written Code of Conduct adopted by CVS Health Corporation's Board of Directors, applicable to all employees of the Company. In addition, the Company has an internal Disclosure Committee, comprised of management from each functional area within the Company, which performs a separate review of disclosure controls and procedures. There are inherent limitations in the effectiveness of any system of internal control over financial reporting.

Based on management's assessment, management concluded that the Company's internal control over financial reporting is effective and provides reasonable assurance that assets are safeguarded and that the financial records are reliable for preparing financial statements as of December 31, 2021.

Ernst & Young LLP, the Company's independent registered public accounting firm, is appointed by CVS Health Corporation's Board of Directors and ratified by CVS Health Corporation's stockholders. They were engaged to render an opinion regarding the fair presentation of the Company's consolidated financial statements as well as conducting an audit of internal control over financial reporting. Their reports included in Item 8 of this Form 10-K are based upon audits conducted in accordance with the standards of the Public Company Accounting Oversight Board (United States).

Changes in internal control over financial reporting

There has been no change in the Company's internal control over financial reporting identified in connection with the evaluation required by paragraph (d) of Rule 13a-15 or Rule 15d-15 that occurred during the fourth quarter ended December 31, 2021 that has materially affected, or is reasonably likely to materially affect, the Company's internal control over financial reporting.

Item 9B. Other Information.

No events have occurred during the fourth quarter ended December 31, 2021 that would require disclosure under this item.

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

Information concerning the Executive Officers of CVS Health Corporation is included in Part I of this 10-K pursuant to General Instruction G to Form 10-K.

The sections of the Proxy Statement under the captions "Committees of the Board as of the Annual Meeting," "Code of Conduct," "Audit Committee Report," and "Biographies of our Incumbent Board Nominees" are incorporated herein by reference.

Item 11. Executive Compensation.

The sections of the Proxy Statement under the captions "Non-Employee Director Compensation" and "Executive Compensation and Related Matters," including "Letter from the Management Planning and Development Committee," "Compensation Committee Report," "Compensation Discussion and Analysis" and "Compensation of Named Executive Officers" are incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

The sections of the Proxy Statement under the captions "Share Ownership of Directors and Certain Executive Officers" and "Share Ownership of Principal Stockholders" are incorporated herein by reference. Those sections contain information concerning security ownership of certain beneficial owners and management and related stockholder matters.

The following table summarizes information about the registrant's common stock that may be issued upon the exercise of options, warrants and rights under all of the Company's equity compensation plans as of December 31, 2021:

	Number of securities to be issued upon exercise of outstanding options, warrants and rights [1] [2] (a)	Weighted average exercise price of outstanding options, warrants and rights (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in first column) [1] (c)
Equity compensation plans approved by stockholders [3]	29,075	$ 74.09	29,585
Equity compensation plans not approved by stockholders [4]	5,064	43.63	—
Total	34,139	$ 72.68	29,585

(1) Shares in thousands.

(2) Consists of: (i) 17,575 shares of common stock underlying outstanding options, (ii) 854 shares of common stock issuable upon the exercise of outstanding stock appreciation rights ("SARs") and (iii) 15,710 shares of common stock issuable on the vesting of outstanding restricted stock units, deferred stock units and performance stock units, assuming target level performance in the case of performance stock units. The number of shares included with respect to outstanding SARs is the number of shares of CVS Health Corporation common stock that would have been issued had the SARs been exercised based on the closing price per share of CVS Health Corporation common stock on December 31, 2021, as reported on the NYSE, which was $103.16.

(3) Consists of the CVS Health 2017 Incentive Compensation Plan.

(4) Consists of the Amended Aetna Inc. 2010 Stock Incentive Plan (the "Aetna Stock Plan"). The Aetna Stock Plan expired on May 21, 2020, therefore there are no securities available for future issuance under this plan.

The Aetna Stock Plan was last approved by Aetna's shareholders at Aetna's 2017 Annual Meeting on May 19, 2017. The Company elected to continue to grant awards under the Aetna Stock Plan to employees of Aetna and its subsidiaries following the completion of the Company's acquisition of Aetna. The Aetna Stock Plan was designed to promote the Company's interests and those of its stockholders and to further align the interests of stockholders and employees by tying awards to total return to stockholders, enabling plan participants to acquire additional equity interests in the Company and providing compensation opportunities dependent upon the Company's performance. The Aetna Stock Plan was not submitted to the Company's stockholders and expired on May 21, 2020. Under the Aetna Stock Plan, eligible participants could be granted stock options to

purchase shares of CVS Health Corporation common stock, SARs, time-vesting and/or performance-vesting incentive stock or incentive units and other stock-based awards.

Item 13. Certain Relationships and Related Transactions, and Director Independence.

The sections of the Proxy Statement under the captions “Independence Determinations for Directors” and “Related Person Transaction Policy” are incorporated herein by reference.

Item 14. Principal Accountant Fees and Services.

The section of the Proxy Statement under the caption “Item 2: Ratification of Appointment of Independent Registered Public Accounting Firm for 2021” is incorporated herein by reference.

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PART IV

Item 15. Exhibits, Financial Statement Schedules.

The following documents are filed as part of this 10-K:

1. Financial Statements. See “Index to Consolidated Financial Statements” in Item 8 of this 10-K.

2. Financial Statement Schedules. All financial statement schedules are omitted because they are not applicable, not required under the instructions, or the information is included in the consolidated financial statements or related notes.

3. Exhibits. The exhibits listed in the “Index to Exhibits” in this Item 15 are filed or incorporated by reference as part of this 10-K. Exhibits marked with an asterisk (*) are management contracts or compensatory plans or arrangements. Exhibits other than those listed are omitted because they are not required to be listed or are not applicable. Pursuant to Item 601(b)(4)(iii) of Regulation S-K, the Registrant hereby agrees to furnish to the Securities and Exchange Commission a copy of any omitted instrument that is not required to be listed.

INDEX TO EXHIBITS

Exhibit	Description
3	**Articles of Incorporation and Bylaws**
3.1	Restated Certificate of Incorporation of the Registrant dated June 4, 2018 (incorporated by reference to Exhibit 3.1C of Registrant's Current Report on Form 8-K filed June 5, 2018).
3.2	By-Laws of the Registrant, as amended and restated July 8, 2020 (incorporated by reference to Exhibit 3.1 to the Registrant's Current Report on Form 8-K filed July 10, 2020).
4	**Instruments defining the rights of security holders, including indentures**
4.1	Specimen common stock certificate (incorporated by reference to Exhibit 4.1 to the Registration Statement of the Registrant ((then known as CVS Corporation) as successor to Melville Corporation) on Form 8-B filed November 4, 1996).
4.2	Senior Indenture dated August 15, 2006, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed August 15, 2006).
4.3	Form of the Registrant's 2021 Floating Rate Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.4	Form of the Registrant's 2021 Note (incorporated by reference to Exhibit 4.4 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.5	Form of the Registrant's 2023 Note (incorporated by reference to Exhibit 4.5 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.6	Form of the Registrant's 2025 Note (incorporated by reference to Exhibit 4.6 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.7	Form of the Registrant's 2028 Note (incorporated by reference to Exhibit 4.7 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.8	Form of the Registrant's 2038 Note (incorporated by reference to Exhibit 4.8 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.9	Form of the Registrant's 2048 Note (incorporated by reference to Exhibit 4.9 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.10	Form of the Registrant's 2024 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed August 15, 2019).
4.11	Form of the Registrant's 2026 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed August 15, 2019).
4.12	Form of the Registrant's 2029 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed August 15, 2019).
4.13	Form of the Registrant's 2027 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).
4.14	Form of the Registrant's 2030 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).
4.15	Form of the Registrant's 2040 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).

4.16	Form of the Registrant's 2050 Note (incorporated by reference to Exhibit 4.4 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).
4.17	Form of the Registrant's 2027 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed on August 21, 2020).
4.18	Form of the Registrant's 2030 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed on August 21, 2020).
4.19	Form of the Registrant's 2040 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed on August 21, 2020).
4.20	Form of the Registrant's 2027 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed on December 16, 2020).
4.21	Form of the Registrant's 2031 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed on December 16, 2020).
4.22	Form of the 2031 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed on August 18, 2021).
4.23	Material terms of outstanding securities that are registered under Section 12 of the 1934 Act as required by Item 202(a)-(d) and (f) of Regulation S-K.
10	**Material Contracts**
10.1	Five Year Credit Agreement dated as of May 11, 2021, by and among the Registrant, the lenders party thereto, and Bank of America, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2021).
10.2	Five Year Credit Agreement, dated as of May 16, 2019, by and among the Registrant, the lenders party thereto and Bank of America N.A., as Administrative Agent (incorporated by reference to Exhibit 10.2 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.3	Amendment No. 1 to Five Year Credit Agreement dated as of May 16, 2019, to the Five Year Credit Agreement dated as of May 17, 2018, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.3 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.4	Five Year Credit Agreement dated as of May 17, 2018, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018).
10.5*	The Registrant's Supplemental Retirement Plan I for Select Senior Management, as amended and restated as of December 31, 2008 (incorporated by reference to Exhibit 10.6 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2009).
10.6*	Form of Enterprise Non-Competition, Non-Disclosure and Developments Agreement between the Registrant and certain of the Registrant's executive officers (incorporated by reference to Exhibit 10.25 of the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013).
10.7*	The Registrant's Deferred Stock Compensation Plan, as amended and restated (incorporated by reference to Exhibit 10.11 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2019).
10.8*	The Registrant's 2007 Employee Stock Purchase Plan, as amended (incorporated by reference to Exhibit 99.2 to the Registrant's Registration Statement on Form S-8 filed May 19, 2020).
10.9*	Universal 409A Definition Document, as amended (incorporated by reference to Exhibit 10.28 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
10.10*	The Registrant's Amended and Restated Deferred Compensation Plan.
10.11*	The Registrant's Partnership Equity Program, as amended (incorporated by reference to Exhibit 10.25 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.12*	The Registrant's Performance-Based Restricted Stock Unit Plan, as amended (incorporated by reference to Exhibit 10.27 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.13*	The Registrant's 2017 Incentive Compensation Plan, as amended (incorporated by reference to Exhibit 99.1 to the Registrant's Registration Statement on Form S-8 filed May 19, 2020).
10.14*	The Registrant's Executive Incentive Plan, as amended (incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017).
10.15*	The Registrant's Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017).
10.16*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.29 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.17*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.30 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).

10.18*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.19*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax) (incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.20*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Post-Tax) (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.21*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018).
10.22*	Form of Performance Stock Unit Agreement (LTIP) - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018).
10.23*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended September 30, 2020).
10.24*	The Registrant's Management Incentive Plan (incorporated by reference to Exhibit 10.27 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2019).
10.25*	The Registrant's Amended and Restated Severance Plan for Non-Store Employees dated October 11, 2021.
10.26*	The Registrant's Performance-Based Restricted Stock Unit Program, as amended (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.27*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.39 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.28*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.40 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.29*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.41 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.30*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax) (incorporated by reference to Exhibit 10.42 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.31*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Post-Tax) (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013).
10.32*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.5 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.33*	Amended and Restated Employment Agreement between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2008).
10.34*	Amendment dated as of December 21, 2012 to the Amended and Restated Employment Agreement between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012).
10.35*	Form of Non-Qualified Stock Option Agreement - Annual Grant between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.37 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.36*	Form of Restricted Stock Unit Agreement - Annual Grant between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.37*	Amendment dated January 22, 2015 to Nonqualified Stock Option Agreements between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed January 23, 2015).
10.38*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.39*	Change in Control Agreement effective as of July 19, 2010 between the Registrant and Eva Boratto (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2019).

10.40*	Restrictive Covenant Agreement dated June 21, 2019 between the Registrant and Eva Boratto (incorporated by reference to Exhibit 10.48 to the registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2019).
10.41*	Separation Agreement dated June 9, 2021 between CVS Pharmacy, Inc. and Eva C. Boratto (incorporated by reference to Exhibit 10.3 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2021).
10.42*	Change in Control Agreement dated December 22, 2008 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012).
10.43*	Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.34 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012).
10.44*	Restricted Stock Unit Agreement - Annual Grant dated April 1, 2016 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.44 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.45*	Restrictive Covenant Agreement dated May 20, 2016 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.45 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.46*	Change in Control Agreement dated October 1, 2012 between the Registrant and Thomas Moriarty (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2015).
10.47*	Restrictive Covenant Agreement dated July 8, 2019 between the Registrant and Thomas Moriarty (incorporated by reference to Exhibit 10.56 of the Registrant's Annual Report on form 10-K for the fiscal year ended December 31, 2019).
10.48*	Amended and Restated Employment Agreement dated November 5, 2020 between the Registrant and Karen S. Lynch (incorporated by reference to Exhibit 10.51 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2020).
10.49*	Restrictive Covenant Agreement dated November 6, 2020 between the Registrant and Karen S. Lynch (incorporated by reference to Exhibit 10.52 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2020).
10.50*	Restrictive Covenant Agreement dated September 29, 2020 between the Registrant and Alan Lotvin (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2021).
10.51*	Change in Control Agreement dated October 15, 2012 between the Registrant and Alan Lotvin (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2021).
10.52*	Letter Agreement dated May 16, 2021 between the Registrant and Shawn Guertin (incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2021).
10.53*	Restrictive Covenant Agreement dated May 16, 2021 between CVS Pharmacy, Inc. and Shawn Guertin (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2021).
10.54*	Change in Control Agreement dated May 16, 2021 between the Registrant and Shawn Guertin (incorporated by reference to Exhibit 10.6 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2021).
10.55*	Form of Nonqualified Stock Option Agreement between the Registrant and selected employees of the Registrant.
10.56*	Descriptions of certain arrangements not embodied in formal documents as described under the heading "Non-Employee Director Compensation" are incorporated herein by reference to the Proxy Statement (when filed).
21	**Subsidiaries of the registrant**
21.1	Subsidiaries of CVS Health Corporation.
23	**Consents of experts and counsel**
23.1	Consent of Ernst & Young LLP.
31	**Rule 13a-14(a)/15d-14(a) Certifications**
31.1	Certification by the Chief Executive Officer.
31.2	Certification by the Chief Financial Officer.
32	**Section 1350 Certifications**
32.1	Certification by the Chief Executive Officer.

32.2	Certification by the Chief Financial Officer.
101	**Interactive Data File**
101	The following materials from the CVS Health Corporation Annual Report on Form 10-K for the fiscal year ended December 31, 2021 formatted in Inline XBRL: (i) the Consolidated Statements of Operations, (ii) the Consolidated Statements of Comprehensive Income, (iii) the Consolidated Balance Sheets, (iv) the Consolidated Statements of Cash Flows, (v) the Consolidated Statements of Shareholders' Equity and (vi) the related Notes to Consolidated Financial Statements. The instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
104	
104	Cover Page Interactive Data File - The cover page from the Company's Annual Report on Form 10-K for the year ended December 31, 2021, formatted in Inline XBRL (included as Exhibit 101).

Item 16. Form 10-K Summary.

None.

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SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

CVS HEALTH CORPORATION

Date: February 9, 2022

By: /s/ SHAWN M. GUERTIN

Shawn M. Guertin

Executive Vice President and Chief Financial Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title(s)	Date
/s/ FERNANDO AGUIRRE	Director	February 9, 2022
Fernando Aguirre		
/s/ C. DAVID BROWN II	Director	February 9, 2022
C. David Brown II		
/s/ JAMES D. CLARK	Senior Vice President - Controller and Chief	February 9, 2022
James D. Clark	Accounting Officer (Principal Accounting Officer)	
/s/ ALECIA A. DECOUDREAUX	Director	February 9, 2022
Alecia A. DeCoudreaux		
/s/ NANCY-ANN M. DEPARLE	Director	February 9, 2022
Nancy-Ann M. DeParle		
/s/ DAVID W. DORMAN	Chair of the Board and Director	February 9, 2022
David W. Dorman		
/s/ ROGER N. FARAH	Director	February 9, 2022
Roger N. Farah		
/s/ ANNE M. FINUCANE	Director	February 9, 2022
Anne M. Finucane		
/s/ SHAWN M. GUERTIN	Executive Vice President and Chief Financial	February 9, 2022
Shawn M. Guertin	Officer (Principal Financial Officer)	
/s/ EDWARD J. LUDWIG	Director	February 9, 2022
Edward J. Ludwig		
/s/ KAREN S. LYNCH	President and Chief Executive Officer	February 9, 2022
Karen S. Lynch	(Principal Executive Officer) and Director	
/s/ JEAN-PIERRE MILLON	Director	February 9, 2022
Jean-Pierre Millon		
/s/ MARY L. SCHAPIRO	Director	February 9, 2022
Mary L. Schapiro		
/s/ WILLIAM C. WELDON	Director	February 9, 2022
William C. Weldon		
/s/ TONY L. WHITE	Director	February 9, 2022
Tony L. White		

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2020

or

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

For the transition period from _____ to_____

Commission file number: 001-01011

cvs-20201231_g1.jpg

CVS HEALTH CORPORATION

(Exact name of registrant as specified in its charter)

Delaware

(State or other jurisdiction of incorporation or organization) (I.R

One CVS Drive, Woonsocket, Rhode Island

(Address of principal executive offices)

Registrant's telephone number, including area code: **(401**

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

Title of each class	Trading Symbol(s)	Name of each excha registere
Common Stock, par value $0.01 per share	CVS	New York Stock

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of Act.

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Sect the Act.

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Sectio of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period registrant was required to file such reports), and (2) has been subject to such filing requirements fo days.

Indicate by check mark whether the registrant has submitted electronically every Interactive Data F be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the precedi (or for such shorter period that the registrant was required to submit such files).

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non filer, a smaller reporting company, or an emerging growth company. See the definitions of "large a filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 1 Exchange Act.

Large accelerated filer	☑	
Non-accelerated filer	☐	S
		E

If an emerging growth company, indicate by check mark if the registrant has elected not to use the for complying with any new or revised financial accounting standards provided pursuant to Section Act.

Indicate by check mark whether the registrant has filed a report on and attestation to its manageme effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-O 7262(b)) by the registered public accounting firm that prepared or issued its audit report.

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the A

The aggregate market value of the registrant's common stock held by non-affiliates was approximately $84,719,366,378 as of June 30, 2020, based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be affiliates of the registrant.

As of February 8, 2021, the registrant had 1,311,354,926 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The following materials are incorporated by reference into this Form 10-K:

Information contained in the definitive proxy statement for CVS Health Corporation's 2021 Annual Meeting of Stockholders, to be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year ended December 31, 2020 (the "Proxy Statement"), is incorporated by reference in Parts III and IV to the extent described therein.

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Unless the context otherwise requires, references to the terms "we," "our" or "us" used throughout this Annual Report on Form 10-K (this "10-K") refer to CVS Health Corporation (a Delaware corporation) ("CVS Health") and its subsidiaries (collectively, the "Company"). References to competitors and other companies throughout this 10-K, including the information incorporated herein by reference, are for illustrative or comparison purposes only and do not indicate that these companies are the Company's or any segment's only competitors or closest competitors.

CAUTIONARY STATEMENT CONCERNING FORWARD-LOOKING STATEMENTS

The Private Securities Litigation Reform Act of 1995 (the "Reform Act") provides a "safe harbor" for forward-looking statements, so long as (1) those statements are identified as forward-looking, and (2) the statements are accompanied by meaningful cautionary statements that identify important factors that could cause actual results to differ materially from those discussed in the statement. We want to take advantage of these safe harbor provisions.

Certain information contained in this 10-K is forward-looking within the meaning of the Reform Act or SEC rules. This information includes, but is not limited to: "Outlook for 2021" of Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A") included in Item 7, "Quantitative and Qualitative Disclosures About Market Risk" included in Item 7A, "Government Regulation" included in Item 1, and "Risk Factors" included in Item 1A. In addition, throughout this 10-K and our other reports and communications, we use the following words or variations or negatives of these words and similar expressions when we intend to identify forward-looking statements:

· *Anticipates*	· *Believes*	· *Can*	· *Continue*	· *Could*
· *Estimates*	· *Evaluate*	· *Expects*	· *Explore*	· *Forecast*
· *Guidance*	· *Intends*	· *Likely*	· *May*	· *Might*
· *Outlook*	· *Plans*	· *Potential*	· *Predict*	· *Probable*
· *Projects*	· *Seeks*	· *Should*	· *View*	· *Will*

All statements addressing the future operating performance of CVS Health or any segment or any subsidiary and/or future events or developments, including statements relating to the projected impact of coronavirus disease 2019 ("COVID-19") on the Company's businesses, investment portfolio, operating results, cash flows and/or financial condition, statements relating to corporate strategy, statements relating to future revenue, operating income or adjusted operating income, earnings per share or adjusted earnings per share, Pharmacy Services segment business, sales results and/or trends and/or operations, Retail/LTC segment business, sales results and/or trends and/or operations, Health Care Benefits segment business, sales results and/or trends, medical cost trends, medical membership, Medicare Part D membership, medical benefit ratios and/or operations, incremental investment spending, interest expense, effective tax rate, weighted-average share count, cash flow from operations, net capital expenditures, cash available for debt repayment, integration synergies, net synergies, integration costs, enterprise modernization, transformation, leverage ratio, cash available for enhancing shareholder value, inventory reduction, turn rate and/or loss rate, debt ratings, the Company's ability to attract or retain customers and clients, store development and/or relocations, new product development, and the impact of industry and regulatory developments, as well as statements expressing optimism or pessimism about future operating results or events, are forward-looking statements within the meaning of the Reform Act.

Forward-looking statements rely on a number of estimates, assumptions and projections concerning future events, and are subject to a number of significant risks and uncertainties and other factors that could cause actual results to differ materially from those statements. Many of these risks and uncertainties and other factors are outside our control. Certain of these risks and uncertainties and other factors are described under "Risk Factors" included in Item 1A of this 10-K; these are not the only risks and uncertainties we face. There can be no assurance that the Company has identified all the risks that affect it. Additional risks and uncertainties not presently known to the Company or that the Company currently believes to be immaterial also may adversely affect the Company's businesses. If any of those risks or uncertainties develops into actual events, those events or circumstances could have a material adverse effect on the Company's businesses, operating results, cash flows, financial condition and/or stock price, among other effects.

You should not put undue reliance on forward-looking statements. Any forward-looking statement speaks only as of the date of this 10-K, and we disclaim any intention or obligation to update or revise forward-looking statements, whether as a result of new information, future events, uncertainties or otherwise.

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PART I

Item 1. Business.

Overview

CVS Health Corporation ("CVS Health"), together with its subsidiaries (collectively, the "Company," "we," "our" or "us"), is a diversified health services company united around a common purpose of helping people on their path to better health. In an increasingly connected and digital world, we are meeting people wherever they are and changing health care to meet their needs. The Company has more than 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 105 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year and expanding specialty pharmacy services. We also serve an estimated 34 million people through traditional, voluntary and consumer-directed health insurance products and related services, including expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

On November 28, 2018 (the "Aetna Acquisition Date"), the Company acquired Aetna Inc. ("Aetna"). As a result of the acquisition of Aetna (the "Aetna Acquisition"), the Company added the Health Care Benefits segment. Certain aspects of Aetna's operations, including products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, are included in the Company's Corporate/Other segment. The consolidated financial statements reflect Aetna's results subsequent to the Aetna Acquisition Date.

The Company has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/ Other.

COVID-19

The COVID-19 pandemic has severely impacted the economies of the U.S. and other countries around the world. Beginning in March 2020, the effects of the COVID-19 pandemic began to emerge in the U.S. The Company executed preparedness plans to maintain continuity of its operations, including transitioning many office-based colleagues to a remote work environment and installing protective equipment in our retail pharmacies. The Company also provided enhanced benefits to its colleagues, including bonuses to frontline colleagues, dependent care financial assistance, paid sick leave for part-time colleagues and paid time off to colleagues who test positive or are quarantined due to exposure to COVID-19.

Our strong local presence and scale in communities across the country enabled us to play an indispensable role in the national response to COVID-19, as well as provide seamless support for our customers wherever they needed us: in our CVS locations, in their homes, and virtually. The Company offered COVID-19 diagnostic testing at more than 4,000 CVS Pharmacy® locations as of December 31, 2020 and launched critical diagnostic testing for the vulnerable senior population in long-term care facilities in partnership with three states. The Company was also selected to administer COVID-19 vaccines in both long-term care facilities and its retail pharmacies. The Company began administering COVID-19 vaccinations in long-term care facilities and in certain of its retail pharmacies during December 2020 and February 2021, respectively, and expects to play a significant role in COVID-19 vaccine administration in the future. In the Health Care Benefits segment, the Company also expanded benefit coverage to its members, including cost-sharing waivers for COVID-19 related treatments, as well as assistance to members through premium credits, telehealth cost-sharing waivers and other investments.

The impact of COVID-19 on the Company's businesses, operating results, cash flows and financial condition in the year ended December 31, 2020, as well as information regarding certain expected impacts of COVID-19 on the Company, is discussed throughout this 10-K.

Pharmacy Services Segment

The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management

services, mail order pharmacy, specialty pharmacy and infusion services, clinical services, disease management services and medical spend management. The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Medicaid managed care ("Managed Medicaid") plans, plans offered on public health insurance exchanges ("Public Exchanges") and private health insurance exchanges ("Private Exchanges" and together with Public Exchanges, "Insurance Exchanges") and other sponsors of health benefit plans throughout the United States. The

Pharmacy Services segment includes retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services. During the year ended December 31, 2020, the Company's PBM filled or managed 2.1 billion prescriptions on a 30-day equivalent basis.

PBM Services

The Company dispenses prescription drugs directly through its mail order dispensing and specialty mail order pharmacies and through pharmacies in its retail network. All prescriptions processed by the Company are analyzed, processed and documented by the Company's proprietary prescription management systems. These systems provide essential features and functionality to allow plan members to utilize their prescription drug benefits. These systems also streamline the process by which prescriptions are processed by staff and network pharmacists by enhancing review of various items through automation, including plan eligibility, early refills, duplicate dispensing, appropriateness of dosage, drug interactions or allergies, over-utilization and potential fraud.

Plan Design Offerings and Administration
The Company administers pharmacy benefit plans for clients who contract with it to facilitate prescription drug coverage and claims processing for their eligible plan members. The Company assists its PBM clients in designing pharmacy benefit plans that help improve health outcomes while minimizing the costs to the client. The Company also assists PBM clients in monitoring the effectiveness of their plans through frequent, informal communications, the use of proprietary software, as well as through formal annual, quarterly and sometimes monthly performance reviews.

The Company makes recommendations to help PBM clients design benefit plans that promote the use of lower cost, clinically appropriate drugs and helps its PBM clients control costs by recommending plan designs that encourage the use of generic equivalents of brand name drugs when such equivalents are available. Clients also have the option, through plan design, to further lower their pharmacy benefit plan costs by setting different member payment levels for different products on their drug lists or "formularies," which helps guide members to choose lower cost alternatives through appropriate financial incentives.

Formulary Management
The Company utilizes an independent panel of doctors, pharmacists and other medical experts, referred to as the CVS Caremark National Pharmacy and Therapeutics Committee, to review and approve the selection of drugs that meet the Company's standards of safety and efficacy for inclusion on one of the Company's template formularies. The Company's formularies provide recommended products in numerous drug classes to help ensure member access to clinically appropriate drugs with alternatives within a class under the client's pharmacy benefit plan, while helping to drive the lowest net cost for clients that select one of the Company's formularies. To help improve clinical outcomes for members and clients, the Company conducts ongoing, independent reviews of all drugs, including those appearing on the formularies and generic equivalent products. Many of the Company's clients choose to adopt a template formulary offering as part of their plan design. PBM clients are given capabilities to offer real time benefits information for a member's specific plan design, provided digitally at the point of prescribing, at the pharmacy and directly to members.

Retail Pharmacy Network Management Services
The Company maintains a national network of approximately 66,000 retail pharmacies, consisting of approximately 40,000 chain pharmacies (which includes CVS Pharmacy locations) and approximately 26,000 independent pharmacies, in the United States, including Puerto Rico, the District of Columbia, Guam and the U.S. Virgin Islands. When a customer fills a prescription in a retail pharmacy, the pharmacy sends prescription data electronically to the Company from the point-of-sale. This data interfaces with the Company's proprietary prescription management systems, which verify relevant plan member data and eligibility, while also performing a drug utilization review to help evaluate clinical appropriateness and safety and confirming that the pharmacy will receive payment for the prescription. The Company also offers a performance program for non-Medicare customers, which can be implemented with either the Company's broad, national network or with any managed network (as allowed by applicable laws and regulations). Under the program, high performing pharmacies are eligible to receive an incremental positive performance payment. The program aligns with key Healthcare Effectiveness Data Information Set measures utilized by the U.S. Centers for Medicare & Medicaid Services ("CMS") and is funded by client fees.

Mail Order Pharmacy Services

The Pharmacy Services segment operates mail order dispensing pharmacies in the United States. Plan members or their prescribers submit prescriptions or refill requests, primarily for maintenance medications, to these pharmacies, and staff pharmacists review these prescriptions and refill requests with the assistance of the Company's prescription management systems. This review may involve communications with the prescriber and, with the prescriber's approval when required, can result in generic substitution, therapeutic interchange or other actions designed to help reduce cost and/or improve quality of

treatment. The Company's mail order dispensing pharmacies have been awarded Mail Service Pharmacy accreditation from URAC, a health care accrediting organization that establishes quality standards for the health care industry.

Specialty Pharmacy and Infusion Services
The Pharmacy Services segment operates specialty mail order pharmacies, retail specialty pharmacy stores and branches for infusion and enteral nutrition services in the United States. The specialty mail order pharmacies are used for delivery of advanced medications to individuals with chronic or genetic diseases and disorders. The Company's specialty mail order pharmacies also have been awarded Specialty Pharmacy accreditation from URAC. Substantially all of the Company's specialty mail order pharmacies also have been accredited by The Joint Commission, which is an independent, not-for-profit organization that accredits and certifies health care programs and organizations in the United States.

Clinical Services
The Company offers multiple clinical programs and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner. These programs are primarily designed to promote better health outcomes and to help target inappropriate medication utilization and non-adherence to medication, each of which may result in adverse medical events that negatively affect member health and client pharmacy and medical spend. These programs include utilization management ("UM"), medication management, quality assurance, adherence and counseling programs to complement the client's plan design and clinical strategies. To help address prescription opioid abuse and misuse, the Company introduced an industry-leading UM approach that limits to seven days the supply of opioids dispensed for certain acute prescriptions for patients who are new to therapy, limits the daily dosage of opioids dispensed based on the strength of the opioid and requires the use of immediate-release formulations of opioids before extended-release opioids are dispensed. The Company's Pharmacy Advisor® program facilitates pharmacist counseling, both face-to-face and over the telephone, to help participating plan members with certain chronic diseases, such as diabetes and cardiovascular conditions, to identify gaps in care, adhere to their prescribed medications and manage their health conditions. The Company also has digital connectivity that helps to lower drug costs for patients by providing expanded visibility to lower cost alternatives through enhanced analytics and data sharing.

Disease Management Programs
The Company's clinical programs and services utilize advanced protocols and offer clients convenience in working with health care providers ("providers") and other third parties. The Company's UM program covers diseases such as rheumatoid arthritis, Parkinson's disease, seizure disorders and multiple sclerosis and is accredited by the National Committee for Quality Assurance ("NCQA"), a private, not-for-profit organization that evaluates, accredits and certifies a wide range of health care organizations.

Medical Benefit Management
The Company's NovoLogix® online preauthorization tool helps identify and capture cost savings opportunities for specialty drugs billed under the medical benefit by identifying outliers to appropriate dosages and costs, and helps to ensure clinically appropriate use of specialty drugs.

Group Purchasing Organization Services
The Company operates a group purchasing organization that negotiates pricing for the purchase of pharmaceuticals and rebates with pharmaceutical manufacturers on behalf of its participants. The Company also provides various administrative, management and reporting services to pharmaceutical manufacturers.

Pharmacy Services Information Systems

The Pharmacy Services segment's claim adjudication platform incorporates architecture that centralizes the data generated from filling mail order prescriptions, adjudicating retail pharmacy claims and delivering other solutions to PBM clients. The Health Engagement Engine® technology and proprietary clinical algorithms help connect the various parts of the enterprise and serve an essential role in cost management and health improvement, leveraging cloud-native technologies and practices. This capability transforms pharmacy data into actionable interventions at key points of care, including in retail, mail and specialty pharmacies as well as in customer care call center operations, leveraging our enterprise data platform to improve the quality of care. The technology leverages assisted artificial intelligence to deliver insights to the business and bring automation to otherwise manual tasks. Specialty

services also connects with our claim adjudication platform and various health plan adjudication platforms with a centralized architecture servicing many clients and members. Operating services, such as Specialty Expedite®, provide an interconnected onboarding solution for specialty medications and branding solutions ranging from fulfillment to total patient management. These services are managed through our new innovative specialty workflow and web platform.

Pharmacy Services Clients

The Company's Pharmacy Services clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D plans, Managed Medicaid plans and plans offered on Insurance Exchanges and other sponsors of health benefit plans throughout the United States. Pharmaceuticals are provided to eligible members in benefit plans maintained by clients and utilize the Company's information systems, among other things, to help perform safety checks, drug interaction screening and identify opportunities for generic substitution. Substantially all of the Pharmacy Services segment's revenues are generated from dispensing and managing prescription drugs to eligible members in benefit plans maintained by clients. In 2018, revenues from Aetna accounted for approximately 9.8% of the Company's consolidated total revenues. On the Aetna Acquisition Date, Aetna became a wholly-owned subsidiary of CVS Health. Subsequent to the Aetna Acquisition Date, revenues from Aetna continue to be reported in the Pharmacy Services segment; however, these revenues are eliminated in the consolidated financial statements.

Pharmacy Services Seasonality

The majority of Pharmacy Services segment revenues are not seasonal in nature.

Pharmacy Services Competition

The Company believes the primary competitive factors in the pharmacy services industry include: (i) the ability to negotiate favorable discounts from drug manufacturers as well as to negotiate favorable discounts from, and access to, retail pharmacy networks; (ii) the ability to identify and apply effective cost management programs utilizing clinical strategies, including the development and utilization of preferred formularies; (iii) the ability to market PBM products and services; (iv) the commitment to provide flexible, clinically-oriented services to clients and be responsive to clients' needs; (v) the quality, scope and costs of products and services offered to clients and their members; and (vi) operational excellence in delivering services. The Pharmacy Services segment has a significant number of competitors offering PBM services, including large, national PBM companies (e.g., Prime Therapeutics and MedImpact), PBMs owned by large national health plans (e.g., the Express Scripts business of Cigna Corporation and the OptumRx business of UnitedHealth) and smaller standalone PBMs.

Retail/LTC Segment

The Retail/LTC segment sells prescription drugs and a wide assortment of health and wellness products and general merchandise, provides health care services through its MinuteClinic® walk-in medical clinics, provides medical diagnostic testing, administers vaccinations for illnesses such as influenza, COVID-19 and shingles and conducts long-term care pharmacy ("LTC") operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. As of December 31, 2020, the Retail/LTC segment operated more than 9,900 retail locations, approximately 1,100 MinuteClinic locations as well as online retail pharmacy websites, LTC pharmacies and on-site pharmacies. During the year ended December 31, 2020, the Retail/LTC segment filled 1.5 billion prescriptions on a 30-day equivalent basis. For the year ended December 31, 2020, the Company dispensed approximately 27.1% of the total retail pharmacy prescriptions in the United States.

Retail/LTC Products and Services

A typical retail store sells prescription drugs and a wide assortment of high-quality, nationally advertised brand name and proprietary brand merchandise. Front store categories include over-the-counter drugs, consumer health products, beauty products and personal care products. LTC operations include distribution of prescription drugs and related consulting and ancillary services. The Company purchases merchandise from numerous manufacturers and distributors. The Company believes that competitive sources are readily available for substantially all of the products carried in its retail stores and the loss of any one supplier would not likely have a material effect on the Retail/LTC segment. The Company's MinuteClinic locations offer a variety of health care services.

Retail/LTC revenues by major product group are as follows:

	Percentage of Revenues		
	2020	2019	2018
Pharmacy [1]	76.9 %	76.7 %	76.4 %
Front store and other [2]	23.1 %	23.3 %	23.6 %
	100.0 %	100.0 %	100.0 %

(1) Pharmacy includes LTC sales and sales in pharmacies within Target Corporation ("Target") and other retail stores.
(2) "Other" represents less than 10% of the "Front store and other" revenue category.

Pharmacy
Pharmacy revenues represented approximately three-fourths of Retail/LTC segment revenues in each of 2020, 2019 and 2018. The Company believes that retail pharmacy operations will continue to represent a critical part of the Company's business due to industry demographics, e.g., an aging American population consuming a greater number of prescription drugs, prescription drugs being used more often as the first line of defense for managing illness, the introduction of new pharmaceutical products, the need for vaccinations and Medicare Part D growth. The Company believes the retail pharmacy business benefits from investment in both people and technology, as well as innovative collaborations with health plans, PBMs and providers. Given the nature of prescriptions, consumers want their prescriptions filled accurately by professional pharmacists using the latest tools and technology, and ready when promised. Consumers also need medication management programs and better information to help them get the most out of their health care dollars. To assist consumers with these needs, the Company has introduced integrated pharmacy health care services that provide an earlier, easier and more effective approach to engaging consumers in behaviors that can help lower costs, improve health and save lives.

Front Store
Front store revenues reflect the Company's strategy of innovating with new and unique products and services, using innovative personalized marketing and adjusting the mix of merchandise to match customers' needs and preferences. A key component of the front store strategy is the ExtraCare® card program, which is one of the largest and most successful retail loyalty programs in the United States. The ExtraCare program allows the Company to balance marketing efforts so it can reward its best customers by providing them with automatic sale prices, customized coupons, ExtraBucks® rewards and other benefits. The Company also offers a subscription-based membership program, CarePass®, under which members are entitled to a suite of benefits delivered over the course of the subscription period, as well as a promotional reward that can be redeemed for future goods and services. The Company continues to launch and enhance new and exclusive brands to create unmatched offerings in beauty products and deliver other unique product offerings, including a full range of high-quality CVS Health® and other proprietary brand products that are only available through CVS stores. The Company currently carries approximately 6,000 CVS Health and proprietary brand products, which accounted for approximately 24% of front store revenues during 2020.

MinuteClinic
As of December 31, 2020, the Company operated approximately 1,100 MinuteClinic locations in the United States. The clinics are staffed by nurse practitioners and physician assistants who utilize nationally established guidelines to deliver a variety of health care services. Payors value these clinics because they provide convenient, high-quality, cost-effective care, in many cases offering an attractive alternative to more expensive sites of care. MinuteClinic is collaborating with the Pharmacy Services and Health Care Benefits segments to help meet the needs of CVS Caremark's client plan members and the Company's health plan members by offering programs that can improve member health and lower costs. MinuteClinic also maintains relationships with leading hospitals, clinics and physicians in the communities we serve to support and enhance quality, access and continuity of care.

On-site Pharmacies
The Company also operates a limited number of pharmacies located at client sites, which provide certain health plan members and customers with a convenient alternative for filling their prescriptions.

Medical Diagnostic Testing

The Company provides medical diagnostic testing primarily through its COVID-19 testing sites located at CVS Pharmacy locations as well as in long-term care facilities, at community-based testing sites in underserved areas, large-scale rapid test sites in select states, and through its Return Ready℠ solution.

Long-term Care Pharmacy Operations
The Retail/LTC segment provides LTC pharmacy services through the Omnicare® business. Omnicare's customers consist of skilled nursing facilities, assisted living facilities, independent living communities, hospitals, correctional facilities, and other health care service providers. The Company provides pharmacy consulting, including monthly patient drug therapy evaluations, to assist in compliance with state and federal regulations and provide proprietary clinical and health management programs. It also provides pharmaceutical case management services for retirees, employees and dependents who have drug benefits under corporate-sponsored health care programs.

Community Location Development

The addition of new community locations has played, and will continue to play, a key role in the Company's continued growth and success. The Company's community location development program focuses on three areas: entering new service areas, adding locations within existing service areas and relocating to more convenient sites. During 2020, the Company opened approximately 55 new community locations, relocated approximately 20 locations, converted approximately 600 locations into HealthHUB® locations and closed approximately 90 locations.

The Company operated over 650 HealthHUB locations as of December 31, 2020. HealthHUBs have a redesigned format that provide enhanced services, offer a care concierge and focus on health and wellness products. HealthHUBs are designed to meet consumer needs and improve the customer experience by providing care that complements physician practices and hospital systems, enabling improved health outcomes and reducing overall health care costs. The Company expects to continue HealthHUB conversions through 2021 and into 2022.

During the last five years, the Company opened approximately 640 new and relocated retail pharmacies, and acquired approximately 225 locations. The Company believes that continuing to assess the appropriateness of its national footprint and identifying more accessible locations are essential components of competing effectively in the current health care environment. As a result, the Company believes that its community location development program is an integral part of its ability to meet the needs of customers and maintain its leadership position in the pharmacy marketplace given the changing health care landscape.

Retail/LTC Information Systems

The Company has continued to invest in information systems to enable it to deliver exceptional customer service, enhance safety and quality, and expand patient care services while lowering operating costs. The proprietary WeCARE Workflow tool supports pharmacy teams by prioritizing work to meet customer expectations, facilitating prescriber outreach, and seamlessly integrating clinical programs. This solution delivers improved efficiency and enhances customer experience, as well as provides a framework to accommodate the evolution of pharmacy practice and the expansion of clinical programs. Our Health Engagement Engine technology and data science clinical algorithms enable the Company to help identify opportunities for pharmacists to deliver face-to-face counseling regarding patient health and safety matters, including medication adherence issues, gaps in care and management of certain chronic health conditions. The Company's digital strategy is to empower the consumer to navigate their pharmacy experience and manage their condition through integrated online and mobile solutions that offer utility and convenience. The Company's LTC digital technology suite, Omniview®, improves the efficiency of customers' operations with tools that include executive dashboards, pre-admission pricing, electronic ordering of prescription refills, proof-of-delivery tracking, access to patient profiles, receipt and management of facility bills, and real-time validation of Medicare Part D coverage, among other capabilities.

Retail/LTC Customers

The success of the Retail/LTC segment's businesses is dependent upon the Company's ability to establish and maintain contractual relationships with pharmacy benefit managers and other payors on acceptable terms. Substantially all of the Retail/LTC segment's pharmacy revenues are derived from pharmacy benefit managers, managed care organizations ("MCOs"), government funded health care programs, commercial employers and other third-party payors. No single Retail/LTC payor accounted for 10% or more of the Company's consolidated total revenues in 2020, 2019 or 2018.

Retail/LTC Seasonality

The majority of Retail/LTC segment revenues, particularly pharmacy revenues, generally are not seasonal in nature. However, front store revenues tend to be higher during the December holiday season. In addition, both pharmacy and front store revenues are affected by the timing and severity of the cough, cold and flu season. Uncharacteristic or extreme weather conditions also can adversely affect consumer shopping patterns and Retail/LTC revenues, expenses and operating results.

During the year ended December 31, 2020, the quarterly earnings progression was also impacted by COVID-19. During March 2020, the Company experienced greater use of 90-day prescriptions, early refills of maintenance medications and increased front store volume as consumers prepared for the COVID-19 pandemic. Subsequent to March 2020, the Company experienced reduced customer traffic in its retail pharmacies and MinuteClinic locations due to shelter-in-place orders as well as reduced new therapy prescriptions as a result of the COVID-19 pandemic. Beginning in the third quarter, the Company saw an increase in diagnostic testing related to the COVID-19 pandemic and in December 2020, the Company began administering COVID-19 vaccinations in long-term care facilities.

Retail/LTC Competition

The retail pharmacy business is highly competitive. The Company believes that it competes principally on the basis of: (i) store location and convenience, (ii) customer service and satisfaction, (iii) product selection and variety, and (iv) price. In the areas it serves, the Company competes with other drugstore chains (e.g., Walgreens and Rite Aid), supermarkets, discount retailers (e.g., Walmart), independent pharmacies, restrictive pharmacy networks, membership clubs, internet companies (e.g., Amazon), and retail health clinics (including urgent care centers), as well as mail order dispensing pharmacies.

LTC pharmacy services are highly regional or local in nature, and within a given geographic area of operation, highly competitive. The Company's largest LTC pharmacy competitor nationally is PharMerica. The Company also competes with numerous local and regional institutional pharmacies, pharmacies owned by long-term care facilities and local retail pharmacies. Some states have enacted "freedom of choice" or "any willing provider" requirements as part of their state Medicaid programs or in separate legislation, which may increase the competition that the Company faces in providing services to long-term care facility residents in these states.

Health Care Benefits Segment

The Health Care Benefits segment is one of the nation's leading diversified health care benefits providers, serving an estimated 34 million people as of December 31, 2020. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make more informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental and behavioral health plans, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services and health information technology ("HIT") products and services. The Health Care Benefits segment also provided workers' compensation administrative services through its Coventry Health Care Workers' Compensation business ("Workers' Compensation business") prior to the sale of this business on July 31, 2020. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates. For periods prior to the Aetna Acquisition Date, the Health Care Benefits segment was comprised only of the Company's SilverScript® PDP business.

Health Care Benefits Products and Services

The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk of medical and dental care costs) as "ASC." Health Care Benefits products and services consist of the following:

- *Commercial Medical*: The Health Care Benefits segment offers point-of-service ("POS"), preferred provider organization ("PPO"), health maintenance organization ("HMO") and indemnity benefit ("Indemnity") plans. Commercial medical products also include health savings accounts ("HSAs") and consumer-directed health plans that combine traditional POS or PPO and/or dental coverage, subject to a deductible, with an accumulating benefit account (which may be funded by the plan sponsor and/or the member in the case of HSAs). Principal products and services are targeted specifically to large multi-site national, mid-sized and small employers, individual insureds and expatriates. The Company offers medical stop loss insurance coverage for certain employers who elect to self-insure their health benefits. Under medical stop loss insurance products, the

Company assumes risk for costs associated with large individual claims and/or aggregate loss experience within an employer's plan above a pre-set annual threshold.

- *Government Medical*: In select geographies, the Health Care Benefits segment offers Medicare Advantage plans, Medicare Supplement plans and prescription drug coverage for Medicare beneficiaries; participates in Medicaid and subsidized Children's Health Insurance Programs ("CHIP"); and participates in demonstration projects for members who are eligible for both Medicare and Medicaid ("Duals"). These Government Medical products are further described below:

- *Medicare Advantage:* Through annual contracts with CMS, the Company offers HMO and PPO products for eligible individuals in certain geographic areas through the Medicare Advantage program. Members typically receive enhanced benefits over traditional fee-for-service Medicare coverage ("Original Medicare"), including reduced cost-sharing for preventive care, vision and other services. The Company offered network-based HMO and/or PPO plans in 45 states and Washington, D.C. in 2020. The Company has expanded to 46 states and Washington, D.C. for 2021. For certain qualifying employer groups, the Company offers Medicare PPO products nationally. When combined with the Company's PDP product, these national PPO plans form an integrated national Insured Medicare product for employers that provides medical and pharmacy benefits.
- *Medicare PDP:* The Company is a national provider of drug benefits under the Medicare Part D prescription drug program. All Medicare eligible individuals are eligible to participate in this voluntary prescription drug plan. Members typically receive coverage for certain prescription drugs, usually subject to a deductible, co-insurance and/or co-payment. On November 30, 2018, the Company completed the sale of Aetna's standalone PDPs to WellCare Health Plans, Inc. effective December 31, 2018. The Company provided administrative services to, and retained the financial results of, the divested plans through 2019. Subsequent to 2019, the Company no longer retains the financial results of the divested plans.
- *Medicare Supplement:* For certain Medicare eligible members, the Company offers supplemental coverage for certain health care costs not covered by Original Medicare. The products included in the Medicare Supplement portfolio help to cover some of the gaps in Original Medicare, and include coverage for Medicare deductibles and coinsurance amounts. The Company offered a wide selection of Medicare Supplement products in 49 states and Washington, D.C. in 2020.
- *Medicaid and CHIP:* The Company offers health care management services to individuals eligible for Medicaid and CHIP under multi-year contracts with government agencies in various states that are subject to annual appropriations. CHIP are state-subsidized insurance programs that provide benefits for families with uninsured children. The Company offered these services on an Insured or ASC basis in 16 states in 2020.
- *Duals:* The Company provides health coverage to beneficiaries who are dually eligible for both Medicare and Medicaid coverage. These members must meet certain income and resource requirements in order to qualify for this coverage. The Company coordinates 100% of the care for these members and may provide them with additional services in order to manage their health care costs.

- *Specialty and Strategic Solutions*: The Health Care Benefits segment has a portfolio of additional health products and services that complement its medical products such as dental plans, behavioral health and employee assistance products, provider network access and vision products. The Company also has a portfolio of transformative products and services aimed at creating a holistic and integrated approach to individual health and wellness. These products and services complement the Commercial Medical and Government Medical products and aim to provide innovative solutions, create integrated experience offerings and enable enhanced care delivery to customers.

Health Care Benefits Provider Networks

The Company contracts with physicians, hospitals and other providers for services they provide to the Company's members. The Company uses a variety of techniques designed to help encourage appropriate utilization of medical services ("utilization") and maintain affordability of quality coverage. In addition to contracts with providers for negotiated rates of reimbursement, these techniques include creating risk sharing arrangements that align economic incentives with providers, the development and implementation of guidelines for the appropriate utilization and the provision of data to providers to enable them to improve health care quality. At December 31, 2020, the Company's underlying nationwide provider network had approximately 1.4 million participating providers. Other providers in the Company's provider networks also include laboratory, imaging, urgent care and other freestanding health facilities.

Health Care Benefits Quality Assessment

CMS uses a 5-star rating system to monitor Medicare health care and drug plans and ensure that they meet CMS's quality standards. CMS uses this rating system to provide Medicare beneficiaries with a tool that they can use to

compare the overall quality of care and level of customer service of companies that provide Medicare health care and drug plans. The rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management and overall customer satisfaction. See “Health Care Benefits Pricing” below in this Item 1 for further discussion of star ratings. The Company seeks Health Plan accreditation for Aetna HMO plans from the NCQA. Health care plans seeking accreditation must pass a rigorous, comprehensive review and must annually report on their performance.

Aetna Life Insurance Company ("ALIC"), a wholly-owned subsidiary of the Company, has received nationwide NCQA PPO Health Plan accreditation. As of December 31, 2020, all of the Company's Commercial HMO and all of ALIC's PPO members who were eligible participated in HMOs or PPOs that are accredited by the NCQA.

The Company's provider selection and credentialing/re-credentialing policies and procedures are consistent with NCQA and URAC, as well as state and federal, requirements. In addition, the Company is certified under the NCQA Credentials Verification Organization ("CVO") certification program for all certification options and has URAC CVO accreditation.

Quality assessment programs for contracted providers who participate in the Company's networks begin with the initial review of health care practitioners. Practitioners' licenses and education are verified, and their work history is collected by the Company or in some cases by the practitioner's affiliated group or organization. The Company generally requires participating hospitals to be certified by CMS or accredited by The Joint Commission, the American Osteopathic Association, or Det Norske Veritas Healthcare.

The Company also offers quality and outcome measurement programs, quality improvement programs, and health care data analysis systems to providers and purchasers of health care services.

Health Care Benefits Information Systems

The Health Care Benefits segment currently operates and supports an end-to-end suite of information technology platforms to support member engagement, enrollment, health benefit administration, care management, service operations, financial reporting and analytics. The multiple platforms are supported by an integration layer to facilitate the transfer of real-time data. There is continued focus and investment in enterprise data platforms, cloud capabilities, digital products to offer innovative solutions and a seamless experience to the Company's members through mobile and web channels. The Company is making concerted investments in emerging technology capabilities such as voice, artificial intelligence and robotics to further automate, reduce cost and improve the experience for all of its constituents. The Health Care Benefits segment is utilizing the full breadth of the Company's assets to build enterprise technology that will help guide our members through their health care journey, provide them a high level of service, enable healthier outcomes and encourage them to take next best actions to lead healthier lives.

Health Care Benefits Customers

Medical membership is dispersed throughout the United States, and the Company also serves medical members in certain countries outside the United States. The Company offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, many of which are available nationwide. Depending on the product, the Company markets to a range of customers including employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans, labor groups and expatriates. For additional information on medical membership, see "Health Care Benefits Segment" in the Management's Discussion and Analysis of Financial Condition and Results of Operations (the "MD&A") included in Item 7 of this 10-K.

The Company markets both Commercial Insured and ASC products and services primarily to employers that sponsor the Company's products for the benefit of their employees and their employees' dependents. Frequently, larger employers offer employees a choice among coverage options, from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to the Company and, through payroll deductions, obtain reimbursement from employees for a percentage of the premiums that is determined by each employer. Some Health Care Benefits products are sold directly to employees of employer groups on a fully employee-funded basis. In some cases, the Company bills the covered individual directly.

The Company offers Insured Medicare coverage on an individual basis as well as through employer groups to their retirees. Medicaid and CHIP members are enrolled on an individual basis. The Company also offers Insured health care coverage to members who are dually-eligible for both Medicare and Medicaid.

Health Care Benefits products are sold through: the Company's sales personnel; independent brokers, agents and consultants who assist in the production and servicing of business; and Private Exchanges. For large plan sponsors,

independent consultants and brokers are frequently involved in employer health plan selection decisions and sales. In some instances, the Company may pay commissions, fees and other amounts to brokers, agents, consultants and sales representatives who place business with the Company. In certain cases, the customer pays the broker for services rendered, and the Company may facilitate that arrangement by collecting the funds from the customer and transmitting them to the broker. The Company

supports marketing and sales efforts with an advertising program that may include television, radio, billboards, print media and social media, supplemented by market research and direct marketing efforts.

The U.S. federal government is a significant customer of the Health Care Benefits segment through contracts with CMS for coverage of Medicare-eligible individuals and federal employee-related benefit programs. Other than the contracts with CMS, the Health Care Benefits segment is not dependent upon a single customer or a few customers the loss of which would have a significant effect on the earnings of the segment. The loss of business from any one, or a few, independent brokers or agents would not have a material adverse effect on the earnings of the Health Care Benefits segment. In both 2020 and 2019, Health Care Benefits segment revenues from the federal government accounted for 13% of the Company's consolidated total revenues. Contracts with CMS for coverage of Medicare-eligible individuals in the Health Care Benefits segment accounted for approximately 92% of the Company's consolidated revenues from the federal government in both 2020 and 2019. No single Health Care Benefits customer accounted for 10% or more of the Company's consolidated total revenues in 2018.

Health Care Benefits Pricing

For Commercial Insured plans, contracts containing the pricing and other terms of the relationship are generally established in advance of the policy period and typically have a duration of one year. Fees under ASC plans are generally fixed for a period of one year.

Generally, a fixed premium rate is determined at the beginning of the policy period for Commercial Insured plans. The Company typically cannot recover unanticipated increases in health care and other benefit costs in the current policy period; however, it may consider prior experience for a product in the aggregate or for a specific customer, among other factors, in determining premium rates for future policy periods. Where required by state laws, premium rates are filed and approved by state regulators prior to contract inception. Future operating results could be adversely affected if the premium rates requested are not approved or are adjusted downward or their approval is delayed by state or federal regulators.

The Company has Medicare Advantage and PDP contracts with CMS to provide HMO, PPO and prescription drug coverage to Medicare beneficiaries in certain geographic areas. Under these annual contracts, CMS pays the Company a fixed per member (or "capitation") payment and/or a portion of the premium, both of which are based on membership and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed capitation payment or premium. PDP contracts also provide a risk-sharing arrangement with CMS to limit the Company's exposure to unfavorable expenses or benefit from favorable expenses. Amounts payable to the Company under the Medicare arrangements are subject to annual revision by CMS, and the Company elects to participate in each Medicare service area or region on an annual basis. Premiums paid to the Company for Medicare products are subject to federal government reviews and audits, which can result, and have resulted, in retroactive and prospective premium adjustments and refunds to the government and/or members. In addition to payments received from CMS, some Medicare Advantage products and all PDP products require a supplemental premium to be paid by the member or sponsoring employer. In some cases these supplemental premiums are adjusted based on the member's income and asset levels. Compared to Commercial Medical products, Medicare contracts generate higher per member per month revenues and higher health care and other benefit costs.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA") ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star ratings." Plans must have a star rating of four or higher (out of five) to qualify for bonus payments. CMS released the Company's 2021 star ratings in October 2020. The Company's 2021 star ratings will be used to determine which of the Company's Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2022. Based on the Company's membership at December 31, 2020, 83% of the Company's Medicare Advantage members were in plans with 2021 star ratings of at least 4.0 stars, consistent with 83% of the Company's Medicare Advantage members being in plans with 2020 star ratings of at least 4.0 stars based on the Company's membership at December 31, 2019.

Rates for Medicare Supplement products are regulated at the state level and vary by state and plan.

Under Insured Medicaid contracts, state government agencies pay the Company fixed monthly rates per member that vary by state, line of business and demographics; and the Company arranges, pays for and manages the health care services provided to Medicaid beneficiaries. These rates are subject to change by each state, and, in some instances, provide for adjustment for health risk factors. CMS requires these rates to be actuarially sound. The Company also receives fees from customers where it provides services under ASC Medicaid contracts. ASC Medicaid contracts generally are for periods of more than one year, and certain of them contain performance incentives and limited financial risk sharing with respect to certain medical, financial

and operational metrics. Under these arrangements, performance is evaluated annually, with associated financial incentive opportunities, and financial risk share obligations are typically limited to a percentage of the fees otherwise payable to the Company. Payments to the Company under Medicaid contracts are subject to the annual appropriation process in the applicable state.

Under Duals contracts, the rate setting process is generally established by CMS in partnership with the state government agency participating in the demonstration project. Both CMS and the state government agency may seek premium and other refunds under certain circumstances, including if the Company fails to comply with CMS regulations or other contractual requirements.

The Company offers HMO and consumer-directed medical and dental plans to federal employees under the Federal Employees Health Benefits ("FEHB") Program and the Federal Employees Dental and Vision Insurance Program. Premium rates and fees for those plans are subject to federal government review and audit, which can result, and have resulted, in retroactive and prospective premium and fee adjustments and refunds to the government and/or members.

Beginning in 2014, the ACA imposed significant new industry-wide fees, assessments and taxes, including an annual levy known as the health insurer fee (the "HIF"). The HIF applies for both 2020 and 2018 and was temporarily suspended for 2019. In December 2019, the HIF was repealed for calendar years after 2020. For additional information on the ACA fees, assessments and taxes, see Note 1 ''Significant Accounting Policies'' included in Item 8 of this 10-K. The Company's goal is to collect premiums and fees where possible, or solve for, all of the ACA-related fees, assessments and taxes.

Health Care Benefits Seasonality

For periods prior to the Aetna Acquisition Date, the Health Care Benefits segment was comprised only of the Company's SilverScript PDP business. The quarterly earnings and operating cash flows of the PDP business are impacted by the Medicare Part D benefit design and changes in the composition of PDP membership. The Medicare Part D standard benefit design results in coverage that varies with a member's cumulative annual out-of-pocket costs. The benefit design generally results in employers or other entities that sponsor the Company's products ("plan sponsors") sharing a greater portion of the responsibility for total prescription drug costs in the early part of the year. As a result, the PDP pay percentage or benefit ratio generally decreases and operating income generally increases as the year progresses. For periods subsequent to the Aetna Acquisition, the Health Care Benefits segment's quarterly operating income progression is also impacted by (i) the seasonality of benefit costs which generally increase during the year as Insured members progress through their annual deductibles and out-of-pocket expense limits and (ii) the seasonality of operating expenses, which are generally the highest during the fourth quarter due primarily to spending to support readiness for the start of the upcoming plan year and marketing associated with Medicare annual enrollment.

During the year ended December 31, 2020, the quarterly earnings progression was also impacted by COVID-19. Beginning in mid-March, the health care system experienced a significant reduction in utilization that is discretionary and the cancellation of elective medical procedures. Utilization remained below historical levels through April, began to recover in May and June and reached more normal levels in the third and fourth quarters, with select geographies impacted by COVID-19 waves. The impact of the deferral of non-essential care was partially offset by COVID-19 testing and treatment costs, as well as planned COVID-19 related investments.

Health Care Benefits Competition

The health care benefits industry is highly competitive, primarily due to a large number of for-profit and not-for-profit competitors, competitors' marketing and pricing and a proliferation of competing products, including new products that are continually being introduced into the marketplace. New entrants into the marketplace, as well as consolidation within the industry, have contributed to and are expected to intensify the competitive environment. In addition, the rapid pace of change as the industry evolves towards a consumer-focused retail marketplace, including Insurance Exchanges, and the increased use of technology to interact with members, providers and customers, increase the risks the Company currently faces from new entrants and disruptive actions by existing competitors compared to prior periods.

The Company believes that the significant factors that distinguish competing health plans include the perceived overall quality (including accreditation status), quality of service, comprehensiveness of coverage, cost (including premium rates, provider discounts and member out-of-pocket costs), product design, financial stability and ratings, breadth and quality of provider networks, ability to offer different provider network options, providers available in such networks, and quality of member support and care management programs. The Company believes that it is competitive on each of these factors. The

Company's ability to increase the number of persons covered by its health plans or to increase Health Care Benefits segment revenues is affected by its ability to differentiate itself from its competitors on these factors. Competition may also affect the availability of services from providers, including primary care physicians, specialists and hospitals.

Insured products compete with local and regional health care benefits plans, health care benefits and other plans sponsored by other large commercial health care benefit insurance companies, health system owned health plans, new entrants into the marketplace and numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association. The largest competitor in Medicare products is Original Medicare. Additional Health Care Benefits segment competitors include other types of medical and dental provider organizations, various specialty service providers (including PBM services providers), health care consultants, financial services companies, integrated health care delivery organizations (networks of providers who also coordinate administrative services for and assume insurance risk of their members), third party administrators ("TPAs"), HIT companies and, for certain plans, programs sponsored by the federal or state governments. Emerging competitors include start up health care benefits plans, technology companies, provider-owned health plans, new joint ventures (including not-for-profit joint ventures among firms from multiple industries), technology firms, financial services firms that are distributing competing products on their proprietary Private Exchanges, and consulting firms that are distributing competing products on their proprietary Private Exchanges, as well as non-traditional distributors such as retail companies. The Company's ability to increase the number of persons enrolled in Insured Commercial Medical products also is affected by the desire and ability of employers to self-fund their health coverage.

The Health Care Benefits segment's ASC plans compete primarily with other large commercial health care benefit companies, numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association and TPAs.

The Health Care Benefits segment's international products compete with local, global and U.S.-based health plans and commercial health care benefit insurance companies, many of whom are licensed in more geographies and have a longer operating history, better brand recognition and greater marketplace presence in one or more geographies.

The provider solutions and HIT marketplaces and products are evolving rapidly. The Company competes for provider solutions and HIT business with other large health plans and commercial health care benefit insurance companies as well as information technology companies and companies that specialize in provider solutions and HIT. Many information technology product competitors have longer operating histories, better brand recognition, greater marketplace presence and more experience in developing innovative products.

In addition to competitive pressures affecting the Company's ability to obtain new customers or retain existing customers, the Health Care Benefits segment's medical membership has been and may continue to be adversely affected by adverse and/or uncertain economic conditions and reductions in workforce by existing customers due to adverse and/or uncertain general economic conditions, especially in the United States and industries where such membership is concentrated.

Health Care Benefits Reinsurance

The Company currently has several reinsurance agreements with non-affiliated insurers that relate to Health Care Benefits insurance policies. The Company entered into these contracts to reduce the risk of catastrophic losses which in turn reduces capital and surplus requirements. The Company frequently evaluates reinsurance opportunities and refines its reinsurance and risk management strategies on a regular basis.

Corporate/Other Segment

The Company presents the remainder of its financial results in the Corporate/Other segment, which primarily consists of:

- Management and administrative expenses to support the Company's overall operations, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information

technology and finance departments, expenses associated with the Company's investments in its transformation and enterprise modernization programs and acquisition-related transaction and integration costs; and

- Products for which the Company no longer solicits or accepts new customers such as large case pensions and long-term care insurance products.

Business Strategy

CVS Health is a different kind of health care company. As a diversified health services company, CVS Health is focused on its purpose of helping people on their path to better health. In an increasingly connected and digital world, the Company is meeting people wherever they are and changing health care to meet their needs. Built on a foundation of unmatched community presence, our diversified model engages one in three Americans each year. This broad reach differentiates CVS Health and fosters an increased level of engagement with customers across the country. Through our innovative new products and services that help manage chronic conditions, our HealthHUB care destinations, and our digital solutions, we are making health care more accessible, more affordable and simply better. The Company believes its strategy oriented around the consumer and being present for all the meaningful moments in health will drive long-term sustainable value and place the Company at the forefront of the evolution of health care.

Generic Sourcing Venture

The Company and Cardinal Health, Inc. ("Cardinal") each have a 50% ownership in Red Oak Sourcing, LLC ("Red Oak"), a generic pharmaceutical sourcing entity. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak. Red Oak does not own or hold inventory on behalf of either company.

Working Capital Practices

The Company funds the growth of its businesses through a combination of cash flow from operations, commercial paper and other short-term borrowings, proceeds from sale-leaseback transactions and long-term borrowings. For additional information on the Company's working capital practices, see "Liquidity and Capital Resources" in the MD&A included in Item 7 of this 10-K. The majority of the Retail/LTC segment non-pharmacy revenues are paid in cash, or with debit or credit cards. Managed care organizations, pharmacy benefit managers, government funded health care programs, commercial employers and other third party insurance programs, which represent the vast majority of the Company's consolidated pharmacy revenues, typically settle in less than 30 days. The remainder of the Company's consolidated pharmacy revenues are paid in cash, or with debit or credit cards. Employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans (with the exception of Medicare Part D services, which are described below), labor groups and expatriates, which represent the vast majority of Health Care Benefits segment revenues, typically settle in less than 30 days. As a provider of Medicare Part D services, the Company contracts annually with CMS. Utilization of services each plan year results in the accumulation of either a receivable from or a payable to CMS. The timing of settlement of the receivable or payable with CMS takes several quarters, which impacts working capital from year to year.

Human Capital

Overview

At CVS Health, we share a single, clear purpose: helping people on their path to better health. We devote significant time and attention to the attraction, development and retention of colleagues to deliver high levels of service to our customers. Our commitment to them includes a competitive rewards package and programs that support our diverse range of colleagues in rewarding and fulfilling careers. As of December 31, 2020, we employed nearly 300,000 colleagues primarily in the United States including in all 50 states, the District of Columbia and Puerto Rico, approximately 71% of whom were full-time.

We believe engaged colleagues produce stronger business results and are more likely to build a career with the Company. Each year we conduct an internal engagement survey that provides colleagues with an opportunity to share their opinions and experiences with respect to their role, their team and the enterprise to help our Board of Directors (the "Board") and our management identify areas where we can improve colleague experience. The survey covers a broad range of topics including development and opportunities, diversity management, recognition, performance, well-being, compliance and continuous improvement. In 2020, greater than 80% of our colleagues participated in the engagement survey, of which greater than 80% responded that they were actively engaged.

The Board and our chief executive officer (“CEO”) provide oversight of our human capital strategy, which consists of the following categories: total rewards; diversity, equity and inclusion; colleague development; and health and safety.

Total Rewards

We recognize how vital our colleagues are to our success and strive to offer comprehensive and competitive wages and benefits to meet the varying needs of our colleagues and their families. The benefits and programs include annual bonuses, 401(k) plans, stock awards, an employee stock purchase plan, health care and insurance benefits, paid time off, flexible work schedules, family leave, dependent care resources, colleague assistance programs and tuition assistance, among many others, depending on eligibility.

In response to the COVID-19 pandemic, we provided enhanced pay and benefits, including bonuses to frontline colleagues, dependent care financial assistance, paid sick leave for part-time colleagues and paid time off to colleagues who test positive or are quarantined due to exposure.

Diversity, Equity & Inclusion

We believe that a diverse workforce creates a healthier, stronger and more sustainable company. We aim to attract, retain and support a diverse workforce that reflects the many customers, patients, members and communities we serve. Our Diversity Management Leadership Council, a cross-functional group of senior leaders appointed by our CEO, works with our Strategic Diversity Management leadership team to intentionally embed diversity across all facets of our business. For our efforts, we have been recognized as a DiversityInc Top 50 Company, named to Bloomberg's 2019 Gender-Equality Index and earned a 100 percent score on the Disability Equality Index, meaning the company is recognized as a "Best Place to Work for Disability Inclusion." The Company discloses information on our diversity, equity and inclusion strategy, programs and progress in our annual Corporate Social Responsibility ("CSR") Report.

As a foundation of equity, we continuously focus on increasing underrepresented populations across our business. In 2020, 70% of our total colleague population and 52% of our colleagues at the manager level and above self-reported as female. In addition, in 2020 our colleagues reported their race/ethnicity as: White (53%), Black/African American (16%), Hispanic/Latino (15%), Asian (11%) and Other (5%). The appendix to our CSR Report includes additional data on the diversity of our workforce.

Our diversity management strategy emphasizes workplace representation, inclusion and belonging, talent acquisition and management and a diverse marketplace. We support 15 Colleague Resource Groups ("CRGs") that include more than 22,000 colleagues across the enterprise. These groups represent a wide range of professional, cultural, ethical and personal affinities and interests, as well as formal mentoring programs. Our CRGs provide our colleagues with an opportunity to connect and network with one another through a particular affinity, culture or interest. Each of our CRGs is sponsored by a senior leader.

Colleague Development

The Company offers a number of resources and programs that attract, engage, develop, advance and retain colleagues. Training and development provides colleagues the support they need to perform well in their current role while planning and preparing for future roles. We offer an online orientation program that pairs new hires with seasoned colleagues and the training continues throughout a colleague's career through in-person, virtual and self-paced learning at all levels. We also provide mentoring, tools and workshops for colleagues to manage their career development. We offer a variety of management and leadership programs that develop incumbent diverse and other high potential colleagues. Our broad training practices include updated, tech-enabled tools and keep our colleagues informed of new developments in our industry that are relevant to their roles. During the year ended December 31, 2020, our colleagues completed nearly 12 million training courses.

Our colleague development program also promotes the importance of compliance across our business. Our colleagues demonstrate this commitment through our annual Code of Conduct training, which 100% of active colleagues completed in 2020. In 2020, we launched more than 75 different training courses as part of our annual Enterprise Compliance Training Program.

Health & Safety

We have a strong commitment to providing a safe working environment.

We utilize Safety Service Plans to analyze data and concentrate on key areas of risk to reduce the chance of workplace incidents. We focus on identifying causes and improving performance when workplace incidents occur. We also engage leaders in promoting a culture of safety. With safety task forces in place at each distribution center, we empower leaders and safety business partners to identify policies, procedures and processes that could improve their own operations.

In addition, from the outset of the COVID-19 pandemic, we took a comprehensive approach to managing occupational health and safety challenges presented by the pandemic. We implemented social distancing practices and enhanced cleaning protocols at all of our locations. We launched a COVID-19 command center to coordinate responsive actions to reports of COVID-positivity among colleagues, including contact tracing, sanitizing and collaborating with public health officials. We distributed personal protective equipment based on our safety professionals' assessment of various activities our colleagues perform. We added engineering controls and enhanced safety features in our retail locations, including protective panels at pharmacy counters and front store checkout stations. We developed travel, work from home, self-quarantine, wellness check, and other HR-related guidance to help colleagues maintain their health and safety while continuing to support the essential operations of the Company.

Intellectual Property

The Company has registered and/or applied to register a variety of trademarks and service marks used throughout its businesses, as well as domain names, and relies on a combination of copyright, patent, trademark and trade secret laws, in addition to contractual restrictions, to establish and protect the Company's proprietary rights. The Company regards its intellectual property as having significant value in the Pharmacy Services, Retail/LTC and Health Care Benefits segments. The Company is not aware of any facts that could materially impact the continuing use of any of its intellectual property.

Government Regulation

Overview

The Company's operations are subject to comprehensive federal, state and local laws and regulations and comparable multiple levels of international regulation in the jurisdictions in which it does business. There also continues to be a heightened level of review and/or audit by federal, state and international regulators of the health and related benefits industry's business and reporting practices. In addition, many of the Company's PBM clients and the Company's payors in the Retail/LTC segment, including insurers, Medicare plans, Managed Medicaid plans and MCOs, are themselves subject to extensive regulations that affect the design and implementation of prescription drug benefit plans that they sponsor. Similarly, the Company's LTC clients, such as skilled nursing facilities, are subject to government regulations, including many of the same government regulations to which the Company is subject.

The laws and rules governing the Company's businesses and interpretations of those laws and rules continue to expand and become more restrictive each year and are subject to frequent change. The application of these complex legal and regulatory requirements to the detailed operation of the Company's businesses creates areas of uncertainty. Further, there are numerous proposed health care, financial services and other laws and regulations at the federal, state and international levels, some of which could adversely affect the Company's businesses if they are enacted. The Company cannot predict whether pending or future federal or state legislation or court proceedings, including fundamental changes to the dynamics of one or more of the industries in which it competes, such as the federal or one or more state governments fundamentally restructuring the Commercial, Medicare or Medicaid marketplace or reducing payments to the Company under or financing for Medicare, Medicaid, dual eligible or special needs programs, increasing its involvement in drug reimbursement, pricing, purchasing, and/or importation or changing the laws governing PBMs, will change various aspects of the industries in which it competes or the health care industry generally or the impact those changes will have on the Company's businesses, operating results, cash flows and/or stock price, but the effects could be materially adverse. The Company has internal control policies and procedures and conducts training and compliance programs for its employees to deter prohibited practices. However, if the Company's employees or agents fail to comply with applicable laws governing its international or other operations, it may face investigations, prosecutions and other legal proceedings and actions which could result in civil penalties, administrative remedies and criminal sanctions. Any failure or alleged failure to comply with applicable laws and regulations summarized below, or any adverse applications or interpretations of, or changes in, the laws and regulations affecting the Company and/or its businesses, could have a material adverse effect on the Company's operating results, financial condition, cash flows and/or stock price. See Item 3 of this 10-K, "Legal Proceedings," for further information.

The Company can give no assurance that its businesses, financial condition, operating results and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business

practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations, including the laws and regulations described in this Government Regulation section, as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's

businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

Laws and Regulations Related to COVID-19

The Families First Coronavirus Response Act (the "Families First Act") and the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") were enacted in March 2020. Each of the Families First Act and the CARES Act requires the Company to provide coverage for COVID-19 related medical services, in many cases without member cost-sharing, in its Insured Health Care Benefits products.

The CARES Act also provides relief funding to providers to reimburse them for health care related expenses incurred in preventing, preparing for and/or responding to COVID-19 (provided no other source is obligated to reimburse those expenses) or lost health care related revenues that are attributable to COVID-19. Under the CARES Act, the Company receives reimbursement for uninsured patients in connection with COVID-19 testing and vaccination as well as monoclonal antibody treatment. Aside from such reimbursement, the Company did not request any funding under the CARES Act. However, in the second quarter of 2020, the Company received $43 million from the CARES Act provider relief fund, all of which was returned to the U.S. Department of Health and Human Services ("HHS") during the second quarter of 2020.

The CARES Act also allows for the deferral of the payment of the employer share of Social Security taxes effective March 27, 2020. The Company has elected to defer its Social Security tax payments in accordance with this provision, and will remit the associated payments in two equal installments on or about December 31, 2021 and December 31, 2022, as required under the CARES Act. The Company deferred approximately $670 million of its Social Security tax payments during the year ended December 31, 2020.

In addition to the Families First Act and the CARES Act, the Company is experiencing an unprecedented level of new laws, regulations, directives and orders from federal, state, county and municipal authorities related to the COVID-19 pandemic, most of which have been issued on an emergency basis with immediate, or in some instances retroactive, effect. These governmental actions include, but are not limited to, requirements to waive member cost-sharing associated with COVID-19 testing and treatment, provide coverage for additional COVID-19-related services, expand the use of telemedicine, suspend precertification or other UM mechanisms (including review of claims for medical necessity), allow earlier or longer renewal of prescriptions, extend grace periods for payments of premiums or limit coverage termination based on non-payment of premiums or fees, modify health benefits coverage eligibility rules to help maintain employee eligibility, and facilitate, accelerate or advance payments to providers. For example, in December 2020, as part of a COVID-19 relief package, Congress enacted a 3.75% payment increase to providers through the Medicare Physician Fee Schedule, which Medicare Advantage plans often use as a benchmark for provider contracts. As a result, in many instances the Company will be contractually required to pass on this payment to its providers, which was not anticipated at the time of bidding.

Related governmental actions have required the Company to close or significantly limit operations at traditional office worksites and affected the hours of operation of MinuteClinic locations and the Company's pharmacies. In some instances, the Company has taken permitted proactive actions consistent with more general regulatory directives, such as expanding home delivery of prescription medications, extending hours of operation for member assistance lines and liberalizing certain other terms of coverage. Similar directives have affected the Company's international operations. The Company anticipates additional mandates and directives from domestic and foreign federal, state, county and local authorities throughout the continuation of the COVID-19 pandemic and for some time thereafter, some of which may result in permanent changes in the Company's operations or the health care and other benefits cost and other risks assumed by the Company. Further, although the Company has seen regulators relax certain requirements in light of the COVID-19 pandemic, such as temporary suspension of certain audits and extensions of certain filing deadlines, failure to provide regulatory relief or accommodations in other areas may result in increased costs or reduced revenue for the Company.

The impact of this governmental activity on the U.S. economy, consumer, customer and health care provider behavior and health care utilization patterns is beyond our knowledge and control. As a result, the financial and/or operational impact these COVID-19 related governmental actions and inactions will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the collective impact could be material and adverse.

Laws and Regulations Related to Multiple Segments of the Company's Business

Laws Related to Reimbursement by Government Programs - The Company is subject to various federal and state laws concerning its submission of claims and other information to Medicare, Medicaid and other federal and state government-sponsored health care programs. Potential sanctions for violating these laws include recoupment or reduction of government reimbursement amounts, civil penalties, treble damages, and exclusion from participation in government health care programs. Such laws include the federal False Claims Act (the "False Claims Act"), the federal anti-kickback statute (the "AKS"), state false claims acts and anti-kickback statutes in most states, the federal "Stark Law" and related state laws. In particular, the False Claims Act prohibits intentionally submitting, conspiring to submit, or causing to be submitted, false claims, records, or statements to the federal government, or intentionally failing to return overpayments, in connection with reimbursement by federal government programs. In addition, any claim for government reimbursement also violates the False Claims Act where it results from a violation of the AKS.

Both federal and state false claims laws permit private individuals to file *qui tam* or "whistleblower" lawsuits on behalf of the federal or state government. Participants in the health and related benefits industry, including the Company, frequently are subject to actions under the False Claims Act or similar state laws. The federal Stark Law generally prohibits physicians from referring Medicare or Medicaid beneficiaries for certain services, including outpatient prescription drugs, to any entity with which the physician, or an immediate family member of the physician, has a financial relationship. The Stark Law further prohibits the entity receiving a prohibited referral from presenting a claim for reimbursement by Medicare or Medicaid for services furnished pursuant to the prohibited referral. Various states have enacted similar laws.

The ACA - The United States Supreme Court is expected to rule on the constitutionality of the ACA by June 2021. If the ACA is deemed unconstitutional, there will likely be significant changes to the laws and rules that govern the Company's businesses. If the ACA is deemed constitutional, there may nevertheless be continued efforts to invalidate, modify, repeal or replace it or portions of it, and the Company expects aspects of the ACA to continue to significantly impact its business operations and operating results, including pricing, medical benefit ratios ("MBRs") and the geographies in which the Company's products are available.

The ACA made broad-based changes to the U.S. health care system. While most of the significant aspects of the ACA became effective during or prior to 2014, parts of the ACA continue to evolve through the promulgation of executive orders, legislation, regulations and guidance as well as ongoing litigation. Additional changes to the ACA and those regulations and guidance at the federal and/or state level are likely, and those changes are likely to be significant. Growing federal and state budgetary pressures make it more likely that any changes, including changes at the state level in response to changes to, or invalidation, repeal or replacement of, the ACA and/or changes in the funding levels and/or payment mechanisms of federally supported benefit programs, will be adverse to us. For example, if any elements of the ACA are invalidated or repealed at the federal level, the Company expects that some states would seek to enact similar requirements, such as prohibiting pre-existing condition exclusions, prohibiting rescission of insurance coverage, requiring coverage for dependents up to age 26, requiring guaranteed renewability of insurance coverage and prohibiting lifetime limits on insurance coverage.

The Company filed a lawsuit in August 2019 to recover the $313 million it was owed under the ACA's risk corridor program, which had been stayed pending the Supreme Court decision. In April 2020, the U.S. Supreme Court ruled that health insurance companies may sue the federal government for amounts owed as calculated under the ACA's temporary risk corridor program. In October 2020, the Company received the $313 million in funds it was owed under the ACA's risk corridor program.

The expansion of health care coverage contemplated by the ACA is being funded in part by reductions to the reimbursements the Company and other health plans are paid by the federal government for Medicare members, among other sources. While not all-inclusive, the following are some of the recent key funding changes related to the ACA (assuming it continues to be implemented in its current form). The Company continues to evaluate these provisions and the related regulations and regulatory guidance to determine the impact that they will have on its business operations and operating results:

- The repeal of the annual non-tax deductible industry-wide HIF for calendar years after 2020. The HIF was $15.5 billion and $14.3 billion for 2020 and 2018, respectively, and suspended for 2019.

- The repeal of the non-tax deductible 40% excise tax on employer-sponsored health care benefits above a certain threshold that was scheduled to begin in 2022.
- Reduced federal matching funds for Medicaid expansion. Starting in 2017, the federal matching rate declined slightly each year until it reached 90 percent in 2020, and will remain there.

The ACA also specifies minimum medical loss ratios ("MLRs") for Commercial and Medicare Insured products, specifies features required to be included in commercial benefit designs, limits commercial individual and small group rating and pricing practices, encourages additional competition (including potential incentives for new participants to enter the marketplace) and significantly increases federal and state oversight of health plans, including regulations and processes that could delay or limit the Company's ability to appropriately increase its health plan premium rates. This in turn could adversely affect the Company's ability to continue to participate in certain product lines and/or geographies that it serves today.

Potential repeal of the ACA, ongoing legislative, regulatory and administrative policy changes to the ACA, the results of federal and state level elections, pending litigation challenging the constitutionality of the ACA or funding for the law and federal budget negotiations continue to create uncertainty about the ultimate impact of the ACA. Given the inherent difficulty of foreseeing the nature and scope of future changes to the ACA and how states, businesses and individuals will respond to those changes, the Company cannot predict the impact on it of future changes to the ACA. It is reasonably possible that invalidation, repeal or replacement of or other changes to the ACA and/or states' responses to such changes, in the aggregate, could have a significant adverse effect on the Company's businesses, operating results and cash flows.

Medicare Regulation - The Company's Medicare Advantage products compete directly with Original Medicare and Medicare Advantage products offered by other Medicare Advantage organizations and Medicare Supplement products offered by other insurers. The Company's Medicare PDP and Medicare Supplement products are products that Medicare beneficiaries who are enrolled in Original Medicare purchase to enhance their Original Medicare coverage.

The Company continues to expand the number of counties in which it offers Medicare products. The Company has expanded its Medicare service area and products in 2021 and is seeking to substantially grow its Medicare membership, revenue and operating results over the next several years, including through growth in Medicare Supplement products. The anticipated organic expansion of the Medicare service area and Medicare products offered and the Medicare-related provisions of the ACA significantly increase the Company's exposure to funding and regulation of, and changes in government policy with respect to and/or funding or regulation of, the various Medicare programs in which the Company participates, including changes in the amounts payable to us under those programs and/or new reforms or surcharges on existing programs. For example, the ACA requires minimum MLRs for Medicare Advantage and Medicare Part D plans of 85%. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS. Due to potential lower utilization of medical services by Medicare beneficiaries during the COVID-19 pandemic, it is possible certain Medicare Advantage contracts may not meet the 85% MLR for consecutive years.

The Company's Medicare Advantage and PDP products are heavily regulated by CMS. The regulations and contractual requirements applicable to the Company and other private participants in Medicare programs are complex, expensive to comply with and subject to change. For example, in the second quarter of 2014, CMS issued a final rule implementing the ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. The precise interpretation, impact and legality of this rule are not clear and are subject to pending litigation. Payments the Company receives from CMS for its Medicare Advantage and Part D businesses also are subject to risk adjustment based on the health status of the individuals enrolled. Elements of that risk adjustment mechanism continue to be challenged by the U.S. Department of Justice (the "DOJ"), the Office of the Inspector General of the HHS (the "OIG") and CMS itself. Substantial changes in the risk adjustment mechanism, including changes that result from enforcement or audit actions, could materially affect the amount of the Company's Medicare reimbursement, require the Company to raise prices or reduce the benefits offered to Medicare beneficiaries, and potentially limit the Company's (and the industry's) participation in the Medicare program.

The Company has invested significant resources to comply with Medicare standards, and its Medicare compliance efforts will continue to require significant resources. CMS may seek premium and other refunds, prohibit the Company from continuing to market and/or enroll members in or refuse to passively enroll members in one or more of the Company's Medicare or Medicare-Medicaid demonstration (historically known as "dual eligible") plans, exclude us from participating in one or more Medicare, dual eligible or dual eligible special needs plan programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS

regulations or its Medicare contractual requirements. The Company's Medicare Supplement products are regulated at the state level and subject to similar significant compliance requirements and risks.

CMS regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare Advantage and PDP beneficiaries. For example, CMS conducts risk adjustment data validation ("RADV") audits of a subset of Medicare Advantage contracts for each contract year.

Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various years for RADV audit, and the number of RADV audits continues to increase. The OIG also is auditing the Company's risk adjustment data and that of other companies, and the Company expects CMS and the OIG to continue auditing risk adjustment data. The Company also has received Civil Investigative Demands ("CIDs") from, and provided documents and information to, the Civil Division of the DOJ in connection with a current investigation of its patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

On October 26, 2018, CMS issued proposed rules related to, among other things, changes to the RADV audit methodology established by CMS in 2012. CMS projects that the changes to the RADV audit methodology would increase its recoveries from Medicare Advantage plans as a result of RADV audits. CMS has requested comments on the proposed rules, including whether the proposed RADV rule change should apply retroactively to audits of Medicare Advantage plans for contract year 2011 and forward. The Company is evaluating the potential adverse effect, which could be material, on the Company's operating results, financial condition, and cash flows if the proposed RADV rule change were adopted as proposed. CMS also has announced that its goal is to subject all Medicare Advantage contracts to either a comprehensive or a targeted RADV audit for each contract year.

A portion of each Medicare Advantage plan's reimbursement is tied to the plan's "star ratings." The star rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management, compliance and overall customer satisfaction. Only Medicare Advantage plans with an overall star rating of four or more stars (out of five stars) are eligible for a quality bonus in their basic premium rates. As a result, the Company's Medicare Advantage plans' operating results in 2021 and going forward will be significantly affected by their star ratings. The Company's star ratings and past performance scores are adversely affected by the compliance issues that arise each year in its Medicare operations. CMS released the Company's 2021 star ratings in October 2020. The Company's 2021 star ratings will be used to determine which of its Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2022. Based on the Company's membership at December 31, 2020, 83% of the Company's Medicare Advantage members were in plans with 2021 star ratings of at least 4.0 stars. CMS also gives PDPs star ratings which affect each PDP's enrollment. Medicare Advantage and PDP plans that are rated less than three stars for three consecutive years are subject to contract termination by CMS. CMS continues to revise its star ratings system to make it harder to achieve four stars or more. Despite the Company's success in achieving high 2021 star ratings and other quality measures and the continuation of its improvement efforts, there can be no assurances that it will be successful in maintaining or improving its star ratings in future years. Accordingly, the Company's Medicare Advantage plans may not be eligible for full level quality bonuses, which could adversely affect the benefits such plans can offer, reduce membership and/or reduce profit margins.

Overall, the Company projects the benchmark payment rates in CMS's April 2020 final notice detailing final Medicare Advantage benchmark payment rates for 2021 will increase funding for the Company's Medicare Advantage business, excluding the impact of the HIF in 2020, by approximately 1.8% in 2021 compared to 2020. This 2021 rate increase only partially offsets the challenge the Company faces from the impact of the increasing cost of medical care (including prescription medications) and CMS local and national coverage decisions that require the Company to pay for services and supplies that are not factored into the Company's bids. The federal government may seek to impose restrictions on the configuration of pharmacy or other provider networks for Medicare Advantage and/or PDP plans, or otherwise restrict the ability of these plans to alter benefits, negotiate prices or establish other terms to improve affordability or maintain viability of products. The Company currently believes that the payments it has received and will receive in the near term are adequate to justify the Company's continued participation in the Medicare Advantage and PDP programs, although there are economic and political pressures to continue to reduce spending on the program, and this outlook could change. In January 2021, CMS issued its final notice detailing final 2022 Medicare Advantage benchmark payment rates. Final 2022 Medicare Advantage rates resulted in an increase in industry benchmark rates of approximately 4.1%.

Going forward, the Company expects CMS, the OIG, the DOJ, other federal agencies and the U.S. Congress to continue to scrutinize closely each component of the Medicare program (including Medicare Advantage, PDPs, demonstration projects such as Medicare-Medicaid plans and provider network access and adequacy), modify the terms and requirements of the program and possibly seek to recast or limit private insurers' roles. It is not possible to predict the outcome of this Congressional or regulatory activity, any of which could materially and adversely affect the Company.

In addition, in November 2020, the HHS released the final Rebate Rule (the "Rebate Rule"), which eliminates the regulatory safe harbor from prosecution under the AKS for rebates from pharmaceutical companies to PBMs in Medicare Part D, replacing it with two far narrower safe harbors designed to directly benefit patients with high out-of-pocket costs and to change the way PBMs are compensated. The new safe harbors are (i) for rebates which are passed on to the patient at the point of sale and (ii) for flat service fee payments made to PBMs which cannot be tied to the list prices of drugs. The Pharmaceutical Care

Management Association (the "PCMA"), which represents PBMs, has filed a suit in an effort to block the Rebate Rule, claiming that the Rebate Rule would lead to higher premiums in Medicare Part D and was adopted in an unlawful manner. It is unclear whether the Rebate Rule will be enforceable, whether pharmaceutical companies will respond by reducing list prices, whether list prices in the private market may also be reduced, and what the resulting impact will be to PBMs or the Company.

340B Drug Pricing Program – The 340B Drug Pricing Program allows eligible covered entities to purchase prescription drugs from manufacturers at a steep discount, and is overseen by the HHS and the Health Resources and Services Administration ("HRSA"). In 2020, a number of pharmaceutical manufacturers began programs that limited covered entities' participation in the program through contract pharmacies arrangements, which the Company has with some covered entities. Enforcement from HHS and HRSA to curb these manufacturer practices will significantly impact the Company's participation in the program in the future.

Anti-Remuneration Laws - Federal law prohibits, among other things, an entity from knowingly and willfully offering, paying, soliciting or receiving, subject to certain exceptions and "safe harbors," any remuneration to induce the referral of individuals or the purchase, lease or order of items or services for which payment may be made under Medicare, Medicaid or certain other federal and state health care programs. A number of states have similar laws, some of which are not limited to services paid for with government funds. Sanctions for violating these federal and state anti-remuneration laws may include imprisonment, criminal and civil fines, and exclusion from participation in Medicare, Medicaid and other federal and state government-sponsored health care programs. Companies involved in public health care programs such as Medicare and/or Medicaid are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The Company has invested significant resources to comply with Medicare and Medicaid program standards. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that the Company's compliance efforts in this area will continue to require significant resources.

Antitrust and Unfair Competition - The U.S. Federal Trade Commission ("FTC") investigates and prosecutes practices that are "unfair trade practices" or "unfair methods of competition." Numerous lawsuits have been filed throughout the United States against pharmaceutical manufacturers, retail pharmacies and/or PBMs under various federal and state antitrust and unfair competition laws challenging, among other things: (i) brand name drug pricing and rebate practices of pharmaceutical manufacturers, (ii) the maintenance of retail or specialty pharmacy networks by PBMs, and (iii) various other business practices of PBMs and retail pharmacies. To the extent that the Company appears to have actual or potential market power in a relevant market or CVS Pharmacy, CVS Specialty or MinuteClinic plays a unique or expanded role in a Pharmacy Services or Health Care Benefits segment product offering, the Company's business arrangements and uses of confidential information may be subject to heightened scrutiny from an anti-competitive perspective and possible challenge by state and/or federal regulators and/or private parties.

Privacy and Confidentiality Requirements - Many of the Company's activities involve the receipt, use and disclosure by the Company of personally identifiable information ("PII") as permitted in accordance with applicable federal and state privacy and data security laws, which require organizations to provide appropriate privacy and security safeguards for such information. In addition to PII, the Company uses and discloses de-identified data for analytical and other purposes when permitted. Additionally, there are industry standards for handling credit card data known as the Payment Card Industry Data Security Standard, which are a set of requirements designed to help ensure that entities that process, store or transmit credit card information maintain a secure environment. Certain states have incorporated these requirements into state laws or enacted other requirements relating to the use and/or disclosure of PII.

The federal Health Insurance Portability and Accountability Act of 1996 and the regulations issued thereunder (collectively, "HIPAA"), as further modified by the American Recovery and Reinvestment Act of 2009 ("ARRA") impose extensive requirements on the way in which health plans, providers, health care clearinghouses (known as "covered entities") and their business associates use, disclose and safeguard protected health information ("PHI"). Further, ARRA requires the Company and other covered entities to report any breaches of PHI to impacted individuals and to the HHS and to notify the media in any states where 500 or more people are impacted by the unauthorized release or use of or access to PHI. Criminal penalties and civil sanctions may be imposed for failing to comply with HIPAA standards. The Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), enacted as part of ARRA, amended HIPAA to impose additional restrictions on third-party funded

communications using PHI and the receipt of remuneration in exchange for PHI. The HITECH Act also extended HIPAA privacy and security requirements and penalties directly to business associates. HHS has begun to audit health plans, providers and other parties to enforce HIPAA compliance, including with respect to data security.

In addition to HIPAA, state health privacy laws apply to the extent they are more protective of individual privacy than is HIPAA, including laws that place stricter controls on the release of information relating to specific diseases or conditions and

requirements to notify members of unauthorized release or use of or access to PHI. States also have adopted regulations to implement provisions of the Financial Modernization Act of 1999 (also known as the Gramm-Leach-Bliley Act ("GLBA")) which generally require insurers, including health insurers, to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a non-affiliated third party. Like HIPAA, GLBA sets a "floor" standard, allowing states to adopt more stringent requirements governing privacy protection. Complying with additional state requirements requires us to make additional investments beyond those the Company has made to comply with HIPAA and GLBA.

The Cybersecurity Information Sharing Act of 2015 encourages organizations to share cyber threat indicators with the federal government and, among other things, directs HHS to develop a set of voluntary cybersecurity best practices for organizations in the health care industry. In addition, states have begun to enact more comprehensive privacy laws and regulations addressing consumer rights to data access, deletion, protection or transparency, such as the California Consumer Privacy Act ("CCPA"). States also are starting to issue regulations and proposed regulations specifically related to cybersecurity, such as the regulations issued by the New York Department of Financial Services. Complying with conflicting cybersecurity regulations, which may differ from state to state, requires significant resources. In addition, differing approaches to state privacy and/or cyber-security regulation and varying enforcement philosophies may materially and adversely affect the Company's ability to standardize its products and services across state lines. Widely-reported large scale commercial data breaches in the United States and abroad increase the likelihood that additional data security legislation will be considered by additional states. These legislative and regulatory developments will impact the design and operation of the Company's businesses, its privacy and security strategy and its web-based and mobile assets.

Finally, each Public Exchange is required to adhere to privacy and security standards with respect to PII, and to impose privacy and security standards that are at least as protective of PII as those the Public Exchange has implemented for itself or non-Public Exchange entities, which include insurers offering plans through the Public Exchange and their designated downstream entities, including PBMs and other business associates. These standards may differ from, and be more stringent than, HIPAA.

Consumer Protection Laws - The federal government has many consumer protection laws, such as the Federal Trade Commission Act, the Federal Postal Service Act and the Consumer Product Safety Act. Most states also have similar consumer protection laws and a growing number of states regulate subscription programs. In addition, the federal government and most states have adopted laws and/or regulations requiring places of public accommodation, health care services and other goods and services to be accessible to people with disabilities. These consumer protection and accessibility laws and regulations have been the basis for investigations, lawsuits and multistate settlements relating to, among other matters, the marketing of loyalty programs, and health care products and services, pricing accuracy, expired front store products, financial incentives provided by drug manufacturers to pharmacies in connection with therapeutic interchange programs, disclosures related to how personal data is used and protected and the accessibility of goods and services to people with disabilities. As a result of the Company's direct-to-consumer activities, including mobile and web-based solutions offered to members and to other consumers, the Company also is subject to federal and state regulations applicable to electronic communications and to other general consumer protection laws and regulations. For example, the CCPA became effective in 2020, and additional federal and state regulation of consumer privacy protection may be proposed or enacted in 2020. The Company expects these new laws and regulations to impact the design of its products and services and the management and operation of its businesses and to increase its compliance costs.

Transparency in Coverage Rule - In October 2020, the HHS released a final rule requiring health insurers to disclose negotiated prices of drugs, medical services, supplies and other covered items to the public. The rule requires group health plans and health insurance issuers in the individual and group markets to disclose cost-sharing information upon request, to a participant, beneficiary, or enrollee, which, unless otherwise indicated, for the purpose of the final rules includes an authorized representative, and require plans and issuers to disclose in-network provider rates, historical out-of-network allowed amounts and the associated billed charges, and negotiated rates for prescription drugs. Disclosure of data in a machine readable file is required beginning in January 2022, and insurers are required to have a consumer tool in place by January 2023. The public disclosure of insurer- or PBM-negotiated price concessions may result in drug manufacturers lowering discounts or rebates, resulting in higher drug costs for patients and impacting the ability of the Company to negotiate drug prices and provide competitive products and services to consumers.

Telemarketing and Other Outbound Contacts - Certain federal and state laws, such as the Telephone Consumer Protection Act and the Telemarketing Sales Rule, give the FTC, the Federal Communications Commission and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Pharmacy and Professional Licensure and Regulation - The Company is subject to a variety of intersecting federal and state statutes and regulations that govern the wholesale distribution of drugs; operation of retail, specialty, infusion, LTC and mail order pharmacies; licensure of facilities and professionals, including pharmacists, technicians, nurses and other health care professionals; registration of facilities with the U.S. Drug Enforcement Administration (the "DEA") and analogous state agencies that regulate controlled substances; packaging, storing, shipping and tracking of pharmaceuticals; repackaging of drug products; labeling, medication guides and other consumer disclosures; interactions with prescribers and health care professionals; compounding of prescription medications; dispensing of controlled and non-controlled substances; counseling of patients; transfers of prescriptions; advertisement of prescription products and pharmacy services; security; inventory control; recordkeeping; reporting to Boards of Pharmacy, the U.S. Food and Drug Administration (the "FDA"), the U.S. Consumer Product Safety Commission, the DEA and related state agencies; and other elements of pharmacy practice. Pharmacies are highly regulated and have contact with a wide variety of federal, state and local agencies with various powers to investigate, inspect, audit or solicit information, including Boards of Pharmacy and Nursing, the DEA, the FDA, the DOJ, HHS and others. Many of these agencies have broad enforcement powers, conduct audits on a regular basis, can impose substantial fines and penalties, and may revoke the license, registration or program enrollment of a facility or professional.

State Insurance, HMO and Insurance Holding Company Regulation - A number of states regulate affiliated groups of insurers and HMOs such as the Company under holding company statutes. These laws may, among other things, require prior regulatory approval of dividends and material intercompany transfers of assets and transactions between the regulated companies and their affiliates, including their parent holding companies. The Company expects the states in which its insurance and HMO subsidiaries are licensed to continue to expand their regulation of the corporate governance and internal control activities of its insurance companies and HMOs. Changes to state insurance, HMO and/or insurance holding company laws or regulations or changes to the interpretation of those laws or regulations, including due to regulators' increasing concerns regarding insurance company and/or HMO solvency due, among other things, to past and expected payor insolvencies, could negatively affect the Company's businesses in various ways, including through increases in solvency fund assessments, requirements that the Company hold greater levels of capital and/or delays in approving dividends from regulated subsidiaries.

PBM offerings of prescription drug coverage under certain risk arrangements may be subject to laws and regulations in various states. Such laws may require that the party at risk become licensed as an insurer, establish reserves or otherwise demonstrate financial viability. Laws that may apply in such cases include insurance laws and laws governing MCOs and limited prepaid health service plans.

The states of domicile of the Company's regulated subsidiaries have statutory risk-based capital ("RBC") requirements for health and other insurance companies and HMOs based on the National Association of Insurance Commissioners' Risk-Based Capital for Insurers Model Act (the "RBC Model Act"). These RBC requirements are intended to assess the capital adequacy of life and health insurers and HMOs, taking into account the risk characteristics of a company's investments and products. The RBC Model Act sets forth the formula for calculating RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual company's business. In general, under these laws, an insurance company or HMO must submit a report of its RBC level to the insurance department or insurance commissioner of its state of domicile for each calendar year. At December 31, 2020, the RBC level of each of the Company's insurance and HMO subsidiaries was above the level that would require regulatory action.

For information regarding restrictions on certain payments of dividends or other distributions by the Company's HMO and insurance company subsidiaries, see Note 12 ''Shareholders' Equity'' included in Item 8 of this 10-K.

The holding company laws for the states of domicile of certain of the Company's subsidiaries also 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 (such as the Company's ultimate parent company, CVS Health) that controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would control the insurance holding company. Control is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person.

Certain states have laws that prohibit submitting a false claim or making a false record or statement in order to secure reimbursement from an insurance company. These state laws vary, and violation of them may lead to the imposition of civil or criminal penalties.

Government Agreements and Mandates - The Company and/or its various affiliates are subject to certain consent decrees, settlement and other agreements, corrective action plans and corporate integrity agreements with various federal, state and local authorities relating to such matters as privacy practices, controlled substances, PDPs, expired products, environmental and safety matters, marketing and advertising practices, PBM, LTC and other pharmacy operations and various other business practices. Certain of these agreements contain ongoing reporting, monitoring and/or other compliance requirements for the Company. Failure to meet the Company's obligations under these agreements could result in civil or criminal remedies, financial penalties, administrative remedies, and/or exclusion from participation in federal health care programs.

Environmental and Safety Regulation - The Company's businesses are subject to various federal, state and local laws, regulations and other requirements pertaining to protection of the environment, public health and employee safety, including, for example, regulations governing the management of hazardous substances, the cleaning up of contaminated sites, and the maintenance of safe working conditions in the Company's retail locations, distribution centers and other facilities. Governmental agencies at the federal, state and local levels continue to focus on the retail and health care sectors' compliance with such laws and regulations, and have at times pursued enforcement activities. Any failure to comply with these regulations could result in fines or other sanctions by government authorities.

ERISA Regulation - The Employee Retirement Income Security Act of 1974 ("ERISA"), provides for comprehensive federal regulation of certain employee pension and benefit plans, including private employer and union sponsored health plans and certain other plans that contract with us to provide PBM services. In general, the Company assists plan sponsors in the administration of their health benefit plans, including the prescription drug benefit portion of those plans, in accordance with the plan designs adopted by the plan sponsors. In addition, the Company may have fiduciary duties where it has specifically contracted with a plan sponsor to accept limited fiduciary responsibility, such as for the adjudication of initial prescription drug benefit claims and/or the appeals of denied claims under a plan. In addition to its fiduciary provisions, ERISA imposes civil and criminal liability on service providers to health plans and certain other persons if certain forms of illegal remuneration are made or received. These provisions of ERISA are broadly written and their application to specific business practices is often uncertain.

Some of the Company's health and related benefits and large case pensions products and services and related fees also are subject to potential issues raised by judicial interpretations relating to ERISA. Under those interpretations, together with U.S. Department of Labor ("DOL") regulations, the Company may have ERISA fiduciary duties with respect to PBM members and/or certain general account assets held under contracts that are not guaranteed benefit policies. As a result, certain transactions related to those general account assets are subject to conflict of interest and other restrictions, and the Company must provide certain disclosures to policyholders annually. The Company must comply with these restrictions or face substantial penalties.

In addition, ERISA generally preempts all state and local laws that relate to employee benefit plans, but the extent of the pre-emption continues to be reviewed by courts, including the U.S. Supreme Court. For example, in December 2020, the U.S. Supreme Court upheld an Arkansas law that, among other things, mandates a particular pricing methodology, establishes an appeals process for a pharmacy when the reimbursement is below the pharmacy's acquisition cost, permits a pharmacy to reverse and rebill if they cannot procure the drug from its wholesaler at a price equal to or less than the reimbursement rate, prohibits a PBM from reimbursing a pharmacy less than the amount it reimburses an affiliate on a per unit basis, and permits a pharmacy to decline to dispense if the reimbursement is lower than the pharmacy's acquisition cost.

Other Legislative Initiatives and Regulatory Initiatives - The U.S. federal and state governments, as well as governments in other countries where the Company does business, continue to enact and seriously consider many broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system and the Company's businesses, operating results and/or cash flows. For example:

- Under the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012 significant, automatic across-the-board budget cuts (known as sequestration) began in March 2013, including Medicare spending cuts of not more than 2% of total program costs per year through 2024. Since then, Congress has extended and modified sequestration a number of times. Currently, the CARES Act suspended Medicare sequestration from May 2020 to the end of December 2020 and extended mandatory sequestration to 2030. The Consolidated Appropriations

Act of 2021 extended the temporary suspension of Medicare sequestration through the end of March 2021. Significant uncertainty remains as to whether and how the U.S. Congress will proceed with actions that create additional federal revenue and/or with entitlement reform. The Company cannot predict future federal Medicare or federal or state Medicaid funding levels or the impact that future federal or state budget actions or entitlement program reform, if it occurs, will have on the Company's businesses, operations or operating results, but the effects could be materially adverse, particularly on the Company's Medicare and/or Medicaid revenues, MBRs and operating results.

- The European Union's ("EU's") General Data Protection Regulation ("GDPR") began to apply across the EU during 2018.
- Other significant legislative and/or regulatory measures which are or recently have been under consideration include the following:
    - Eliminating payment of manufacturer's rebates on prescription drugs to PBMs, PDPs and Managed Medicaid organizations in connection with federally funded health care programs.
    - Imposing requirements and restrictions on the design and/or administration of pharmacy benefit plans offered by the Company's and its clients' health plans and/or its PBM clients and/or the services the Company provides to those clients, including prohibiting "differential" or "spread" pricing in PBM contracts; restricting or eliminating the use of formularies for prescription drugs; restricting the Company's ability to require members to obtain drugs through a home delivery or specialty pharmacy; restricting the Company's ability to place certain specialty or other drugs in the higher cost tiers of its pharmacy formularies; restricting the Company's ability to make changes to drug formularies and/or clinical programs; limiting or eliminating rebates on pharmaceuticals; requiring the use of up front purchase price discounts on pharmaceuticals in lieu of rebates; restricting the Company's ability to configure its health plan and retail pharmacy provider networks, including use of CVS Pharmacy locations; and restricting or eliminating the use of certain drug pricing methodologies.
    - Increasing federal or state government regulation of, or involvement in, the pricing and/or purchasing of drugs.
    - Restricting the Company's ability to limit providers' participation in its networks and/or remove providers from its networks by imposing network adequacy requirements or otherwise (including in its Medicare and Commercial Health Care Benefits products).
    - Imposing assessments on (or to be collected by) health plans or health carriers that may or may not be passed through to their customers. These assessments may include assessments for insolvency, the uninsured, uncompensated care, Medicaid funding or defraying health care provider medical malpractice insurance costs.
    - Mandating coverage by the Company's and its clients' health plans for additional conditions and/or specified procedures, drugs or devices (e.g., high cost pharmaceuticals, experimental pharmaceuticals and oral chemotherapy regimens).
    - Regulating electronic connectivity.
    - Mandating or regulating the disclosure of provider fee schedules, manufacturer's rebates and other data about the Company's payments to providers and/or payments the Company receives from pharmaceutical manufacturers.
    - Mandating or regulating disclosure of provider outcome and/or efficiency information.
    - Prescribing or limiting members' financial responsibility for health care or other covered services they utilize, including restricting "surprise" bills by providers and by specifying procedures for resolving "surprise" bills.
    - Prescribing payment levels for health care and other covered services rendered to the Company's members by providers who do not have contracts with the Company.
    - Assessing the medical device status of HIT products and/or solutions, mobile consumer wellness tools and clinical decision support tools, which may require compliance with FDA requirements in relation to some of these products, solutions and/or tools.
    - Restricting the ability of employers and/or health plans to establish or impose member financial responsibility.
    - Amending or supplementing ERISA to impose greater requirements on PBMs or the administration of employer-funded benefit plans or limit the scope of current ERISA pre-emption, which would among other things expose the Company and other health plans to expanded liability for punitive and other extra-contractual damages and additional state regulation.

It is uncertain whether the Company can counter the potential adverse effects of such potential legislation or regulation on its operating results or cash flows, including whether it can recoup, through higher premium rates, expanded membership or other measures, the increased costs of mandated coverage or benefits, assessments, fees,

taxes or other increased costs, including the cost of modifying its systems to implement any enacted legislation or regulations.

The Company's businesses also may be affected by other legislation and regulations. The Dodd-Frank Wall Street Reform and Consumer Protection Act creates incentives for whistleblowers to speak directly to the government rather than utilizing internal compliance programs and reduces the burden of proof under the Foreign Corrupt Practices Act of 1977 (the "FCPA"). There also are laws and regulations that set standards for the escheatment of funds to states.

Health savings accounts, health reimbursement arrangements and flexible spending accounts and certain of the tax, fee and subsidy provisions of the ACA also are regulated by the U.S. Department of the Treasury and the Internal Revenue Service.

The Company also may be adversely affected by court and regulatory decisions that expand or revise the interpretations of existing statutes and regulations or impose medical malpractice or bad faith liability. Federal and state courts, including the U.S. Supreme Court, continue to consider cases, and federal and state regulators continue to issue regulations and interpretations, addressing bad faith liability for denial of medical claims, the scope of ERISA's fiduciary duty requirements, the scope of the False Claims Act and the pre-emptive effect of ERISA on state laws.

Contract Audits - The Company is subject to audits of many of its contracts, including its PBM client contracts, its PBM rebate contracts, its PBM network contracts, its contracts relating to Medicare Advantage and/or Medicare Part D, the agreements the Company's pharmacies enter into with other payors, its Medicaid contracts and its customer contracts. Because some of the Company's contracts are with state or federal governments or with entities contracted with state or federal agencies, audits of these contracts are often regulated by the federal or state agencies responsible for administering federal or state benefits programs, including those which operate Medicaid fee for service plans, Managed Medicaid plans, Medicare Part D plans or Medicare Advantage organizations.

Federal Employee Health Benefits Program - The Company's subsidiaries contract with the Office of Personnel Management (the "OPM") to provide managed health care services under the FEHB program in their service areas. These contracts with the OPM and applicable government regulations establish premium rating arrangements for this program. OPM regulations require that community-rated FEHB plans meet a FEHB program-specific minimum MLR by plan code and market. Managing to these rules is complicated by the simultaneous application of the minimum MLR standards and associated premium rebate requirements of the ACA. The Company also has a contractual arrangement with carriers for the FEHB program, such as the BlueCross BlueShield Association, to provide pharmacy services to federal employees, postal workers, annuitants, and their dependents under the Government-wide Service Benefit Plan, as authorized by the FEHB Act and as part of the FEHB program. Additionally, the Company manages certain FEHB plans on a "cost-plus" basis. These arrangements subject the Company to certain aspects of the FEHB Act, and other federal regulations, such as the FEHB Acquisition Regulation, that otherwise would not be applicable to the Company. The OPM also is auditing the Company and its other contractors to, among other things, verify that plans meet their applicable FEHB program-specific MLR and the premiums established under the OPM's Insured contracts and costs allocated pursuant to the OPM's cost-based contracts are in compliance with the requirements of the applicable FEHB program. The OPM may seek premium refunds or institute other sanctions against the Company if it fails to comply with the FEHB program requirements.

Clinical Services Regulation - The Company provides clinical services to health plans, PBMs and providers for a variety of complex and common medical conditions, including arranging for certain members to participate in disease management programs. State laws regulate the practice of medicine, the practice of pharmacy, the practice of nursing and certain other clinical activities. Clinicians engaged in a professional practice in connection with the provision of clinical services must satisfy applicable state licensing requirements and must act within their scope of practice.

Third Party Administration and Other State Licensure Laws - Many states have licensure or registration laws governing certain types of administrative organizations, such as PPOs, TPAs and companies that provide utilization review services. Several states also have licensure or registration laws governing the organizations that provide or administer consumer card programs (also known as cash card or discount card programs).

International Regulation - The Company has insurance licenses in several foreign jurisdictions and does business directly or through local affiliations in numerous countries around the world. The Company has taken steps to be able to continue to serve customers in the European Economic Area following the United Kingdom's exit from the EU ("Brexit"). However, the impact of Brexit on the Company's international business and operating results is uncertain.

The Company's international operations are subject to different, and sometimes more stringent, legal and regulatory requirements, which vary widely by jurisdiction, including anti-corruption laws; economic sanctions laws; various privacy, insurance, tax, tariff and trade laws and regulations; corporate governance, privacy, data protection (including the EU's General Data Protection Regulation which began to apply across the EU during 2018), data mining, data transfer, labor and employment, intellectual property, consumer protection and investment laws and regulations; discriminatory licensing procedures; compulsory cessions of reinsurance; required localization of records and funds; higher premium and income taxes; limitations on dividends and repatriation of capital; and

requirements for local participation in an insurer's ownership. In addition, the expansion of the Company's operations into foreign countries increases the Company's exposure to the anti-bribery, anti-corruption and anti-money laundering provisions of U.S. law, including the FCPA, and corresponding foreign laws, including the U.K. Bribery Act 2010 (the "UK Bribery Act").

Anti-Corruption Laws - The FCPA prohibits offering, promising or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. The Company also is subject to applicable anti-corruption laws of the jurisdictions in which it operates. In many countries outside the United States, health care professionals are employed by the government. Therefore, the Company's dealings with them are subject to regulation under the FCPA. Violations of the FCPA and other anti-corruption laws may result in severe criminal and civil sanctions as well as other penalties, and there continues to be a heightened level of FCPA enforcement activity by the U.S. Securities and Exchange Commission (the "SEC") and the DOJ. The UK Bribery Act is an anti-corruption law that is broader in scope than the FCPA and applies to all companies with a nexus to the United Kingdom. Disclosures of FCPA violations may be shared with the UK authorities, thus potentially exposing companies to liability and potential penalties in multiple jurisdictions.

Anti-Money Laundering Regulations - Certain lines of the Company's businesses are subject to Treasury anti-money laundering regulations. Those lines of business have implemented anti-money laundering policies designed to ensure their compliance with the regulations. The Company also is subject to anti-money laundering laws in non-U.S. jurisdictions where it operates.

Office of Foreign Assets Control - The Company also is subject to regulation by the Office of Foreign Assets Control of the U.S. Department of Treasury ("OFAC"). OFAC administers and enforces economic and trade sanctions based on U.S. foreign policy and national security goals against targeted foreign countries and regimes, terrorists, international narcotics traffickers, those engaged in activities related to the proliferation of weapons of mass destruction, and other threats to the national security, foreign policy or economy of the United States. In addition, the Company is subject to similar regulations in the non-U.S. jurisdictions in which it operates.

FDA Regulation - The FDA regulates the Company's compounding pharmacy and clinical research operations. The FDA also generally has authority to, among other things, regulate the manufacture, distribution, sale and labeling of medical devices (including hemodialysis devices such as the device the Company is developing and mobile medical devices) and many products sold through retail pharmacies, including prescription drugs, over-the-counter medications, cosmetics, dietary supplements and certain food items. In addition, the FDA regulates the Company's activities as a distributor of store brand products.

Laws and Regulations Related to the Pharmacy Services Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state and local statutes and regulations governing the operation of its Pharmacy Services segment specifically. Among these are the following:

PBM Laws and Regulation - Legislation and/or regulations seeking to regulate PBM activities in a comprehensive manner have been proposed or enacted in a number of states. This legislation could adversely affect the Company's ability to conduct business on commercially reasonable terms in states where the legislation is in effect and the Company's ability to standardize its PBM products and services across state lines. In addition, certain quasi-regulatory organizations, including the National Association of Boards of Pharmacy and the National Association of Insurance Commissioners ("NAIC") and the National Council of Insurance Legislators, have issued model regulations or may propose future regulations concerning PBMs and/or PBM activities. Similarly, credentialing organizations such as NCQA and URAC may establish voluntary standards regarding PBM, mail order pharmacy and/or specialty pharmacy activities. While the actions of these quasi-regulatory or standard-setting organizations do not have the force of law, they may influence states to adopt their requirements or recommendations and influence client requirements for PBM, mail order pharmacy and/or specialty pharmacy services. Moreover, any standards established by these organizations could also impact the Company's health plan clients and/or the services provided to those clients and/or the Company's health plans.

The Company's PBM activities also are regulated directly and indirectly at the federal and state levels, including being subject to the False Claims Act and state false claims acts and the AKS and state anti-kickback laws. These laws and regulations govern, and proposed legislation and regulations may govern and/or further restrict, critical PBM practices, including disclosure, receipt and retention of rebates and other payments received from pharmaceutical manufacturers; use of, administration of and/or changes to drug formularies, maximum allowable cost ("MAC") list pricing, average wholesale prices ("AWP") and/or clinical programs; the offering to plan sponsors of pricing that includes retail network "differential" or "spread" (i.e., a difference between the drug price charged to

the plan sponsor by a PBM and the price paid by the PBM to the dispensing provider); disclosure of data to third parties; drug UM practices; the level of duty a PBM owes its customers; configuration of pharmacy networks; the operations of the Company's pharmacies (including audits of its pharmacies); disclosure of negotiated provider reimbursement rates; disclosure of fees associated with administrative service agreements and patient care programs that are attributable to members' drug utilization; and registration or licensing of PBMs. Failure by the

Company or one of its PBM services suppliers to comply with these laws or regulations could result in material fines and/or sanctions and could have a material adverse effect on the Company's operating results and/or cash flows.

The Company's PBM service contracts, including those in which the Company assumes certain risks under performance guarantees or similar arrangements, are generally not subject to insurance regulation by the states. However, state departments of insurance are increasing their oversight of PBM activities due to legislation passing in a number of states requiring PBMs to register or obtain a license with the department. Rulemaking is either underway or has already taken place in a number of states with the areas of focus on licensure requirements, pharmacy reimbursement for generics (MAC reimbursement) and pharmacy audits - most of which fall under the state insurance code.

Most-Favored-Nations Rule - In November 2020, HHS released the Most-Favored-Nations Rule (the "MFN Rule"), which requires CMS to take a most-favored-nation approach in calculating payment for Medicare Part B drugs. The MFN Rule will test paying Part B drugs at comparable amounts to the lowest adjusted price paid by any country in the Organization for Economic Co-operation and Development that has a Gross Domestic Product ("GDP") per capita that is at least 60% of the U.S. GDP per capita. The MFN Rule will also test a redesign of the percentage add-on payment structure under Medicare Part B to remove incentives for use of higher-cost drugs through a flat per-dose add-on payment, and will include a financial hardship exemption for participants. The mandatory MFN Rule will operate for seven years, from January 1, 2021 to December 31, 2027. Over the course of the model, CMS will monitor and evaluate the impact of the MFN Rule on beneficiary access to drugs, program costs, and the quality of care for beneficiaries. Further, CMS commits to assess initial impacts of the MFN Rule on quality of care, including access to drugs, prior to beginning performance year 5. Multiple pharmaceutical manufacturers have sued HHS over the rule, and it is currently delayed due to a temporary restraining order prohibiting CMS from implementing it. If implemented, the MFN Rule may impact the ability of the Company to negotiate drug prices and provide competitive products and services to consumers.

Pharmacy Network Access Legislation - Medicare Part D and a majority of states now have some form of legislation affecting the Company's (and its health plans' and its health plan clients') ability to limit access to a pharmacy provider network or remove pharmacy network providers. For example, certain "any willing provider" legislation may require the Company or its clients to admit a nonparticipating pharmacy if such pharmacy is willing and able to meet the plan's price and other applicable terms and conditions for network participation. These laws could negatively affect the services and economic benefits achievable through a limited pharmacy provider network. Also, a majority of states now have some form of legislation affecting the Company's ability (and the Company's and its client health plans' ability) to conduct audits of network pharmacies regarding claims submitted to the Company for payment. These laws could negatively affect the Company's ability to recover overpayments of claims submitted by network pharmacies that the Company identifies through pharmacy audits.

Pharmacy Pricing Legislation - A number of states have passed legislation regulating the Company's ability to manage and establish MACs for generic prescription drugs. MAC methodology is a common cost management practice used by private and public payors (including CMS) to pay pharmacies for dispensing generic prescription drugs. MAC prices specify the allowable reimbursement by a PBM for a particular strength and dosage of a generic drug that is available from multiple manufacturers but sold at different prices. State legislation can regulate the disclosure of MAC prices and MAC price methodologies, the kinds of drugs that a PBM can pay for at a MAC price, and the rights of pharmacies to appeal a MAC price established by a PBM. These laws could negatively affect the Company's ability to establish MAC prices for generic drugs.

Formulary and Plan Design Regulation - A number of government entities regulate the administration of prescription drug benefits. HHS regulates how Medicare Part D formularies are developed and administered, including requiring the inclusion of all drugs in certain classes and categories, subject to limited exceptions. Under the ACA, CMS imposes drug coverage requirements for health plans required to cover essential health benefits, including plans offered through federal or state Public Exchanges. Additionally, the NAIC and health care accreditation agencies like NCQA and URAC have developed model acts and standards for formulary development that are often incorporated into government requirements. Many states regulate the scope of prescription drug coverage, as well as the delivery channels to receive prescriptions, for insurers, MCOs and Medicaid managed care plans. The increasing government regulation of formularies could significantly affect the Company's ability to develop and administer formularies, pharmacy networks and other plan design features on behalf of its insurer, MCO and other clients. Similarly, some states prohibit health plan sponsors from implementing certain restrictive

pharmacy benefit plan design features. This regulation could limit or preclude (i) limited networks, (ii) a requirement to use particular providers, (iii) copayment differentials among providers and (iv) formulary tiering practices.

Laws and Regulations Related to the Retail/LTC Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state and local statutes and regulations governing the operation of its Retail/LTC segment specifically. Among these are the following:

Retail Medical Clinics - States regulate retail medical clinics operated by nurse practitioners or physician assistants through physician oversight, clinic and lab licensure requirements and the prohibition of the corporate practice of medicine. A number of states have implemented or proposed laws or regulations that impact certain components of retail medical clinic operations such as physician oversight, signage, third party contracting requirements, bathroom facilities, and scope of services. These laws and regulations may affect the operation and expansion of the Company's owned and managed retail medical clinics.

Other Laws - Other federal, state and local laws and regulations also impact the Company's retail operations, including laws and regulations governing the practice of optometry, the practice of audiology, the provision of dietician services and the sale of durable medical equipment, contact lenses, eyeglasses, hearing aids and alcohol.

Laws and Regulations Related to the Health Care Benefits Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state, local and international statutes and regulations governing its Health Care Benefits segment specifically.

Overview - Differing approaches to state insurance regulation and varying enforcement philosophies may materially and adversely affect the Company's ability to standardize its Health Care Benefits products and services across state lines. These laws and regulations, including the ACA, restrict how the Company conducts its business and result in additional burdens and costs to the Company. Significant areas of governmental regulation include premium rates and rating methodologies, underwriting rules and procedures, required benefits, sales and marketing activities, provider rates of payment, restrictions on health plans' ability to limit providers' participation in their networks and/or remove providers from their networks and financial condition (including reserves and minimum capital or risk based capital requirements). These laws and regulations are different in each jurisdiction and vary from product to product.

Each health insurer and HMO must file periodic financial and operating reports with the states in which it does business. In addition, health insurers and HMOs are subject to state examination and periodic license renewal. Applicable laws also restrict the ability of the Company's regulated subsidiaries to pay dividends, and certain dividends require prior regulatory approval. In addition, some of the Company's businesses and related activities may be subject to PPO, MCO, utilization review or TPA-related licensure requirements and regulations. These licensure requirements and regulations differ from state to state, but may contain provider network, contracting, product and rate, financial and reporting requirements. There also are laws and regulations that set specific standards for the Company's delivery of services, payment of claims, fraud prevention, protection of consumer health information, and payment for covered benefits and services.

Required Regulatory Approvals - The Company must obtain and maintain regulatory approvals to price, market and administer many of its Health Care Benefits products. Supervisory agencies, including CMS, the Center for Consumer Information and Insurance Oversight and the DOL, as well as state health, insurance, managed care and Medicaid agencies, have broad authority to take one or more of the following actions:

- Grant, suspend and revoke the Company's licenses to transact business;
- Suspend or exclude the Company from participation in government programs;
- Suspend or limit the Company's authority to market products;
- Regulate many aspects of the products and services the Company offers, including the pricing and underwriting of many of its products and services;
- Assess damages, fines and/or penalties;
- Terminate the Company's contract with the government agency and/or withhold payments from the government agency to the Company;

- Impose retroactive adjustments to premiums and require the Company to pay refunds to the government, customers and/or members;
- Restrict the Company's ability to conduct acquisitions or dispositions;

- Require the Company to maintain minimum capital levels in its subsidiaries and monitor its solvency and reserve adequacy;
- Regulate the Company's investment activities on the basis of quality, diversification and other quantitative criteria; and/or
- Exclude the Company's plans from participating in Public Exchanges if they are deemed to have a history of "unreasonable" premium rate increases or fail to meet other criteria set by HHS or the applicable state.

The Company's operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time the Company receives subpoenas and other requests for information from, federal, state and international supervisory and enforcement agencies, attorneys general and other state, federal and international governmental authorities and legislators.

Commercial Product Pricing and Underwriting Restrictions - Pricing and underwriting regulation by states limits the Company's underwriting and rating practices and those of other health insurers, particularly for small employer groups, and varies by state. In general, these limitations apply to certain customer segments and limit the Company's ability to set prices for new or renewing groups, or both, based on specific characteristics of the group or the group's prior claim experience. In some states, these laws and regulations restrict the Company's ability to price for the risk it assumes and/or reflect reasonable costs in the Company's pricing.

The ACA expanded the premium rate review process by, among other things, requiring the Company's Commercial Insured rates to be reviewed for "reasonableness" at either the state or the federal level. HHS established a federal premium rate review process that generally applies to proposed premium rate increases equal to or exceeding a federally (or lower state) specified threshold. HHS's rate review process imposes additional public disclosure requirements as well as additional review on filings requesting premium rate increases equal to or exceeding this "reasonableness" threshold. These combined state and federal review requirements may prevent, further delay or otherwise affect the Company's ability to price for the risk it assumes, which could adversely affect its MBRs and operating results, particularly during periods of increased utilization of medical services and/or medical cost trend or when such utilization and/or trend exceeds the Company's projections.

The ACA also specifies minimum MLRs of 85% for large group Commercial products and 80% for individual and small group Commercial products. Because the ACA minimum MLRs are structured as "floors" for many of their requirements, states have the latitude to enact more stringent rules governing these restrictions. For Commercial products, states have and may adopt higher minimum MLR requirements, use more stringent definitions of "medical loss ratio," incorporate minimum MLR requirements into prospective premium rate filings, require prior approval of premium rates or impose other requirements related to minimum MLR. Minimum MLR requirements and similar actions further limit the level of margin the Company can earn in its Insured Commercial products while leaving the Company exposed to medical costs that are higher than those reflected in its pricing. The Company also may be subject to significant fines, penalties, premium refunds and litigation if it fails to comply with minimum MLR laws and regulations.

In addition, the Company requested increases in its premium rates in its Commercial Health Care Benefits business for 2020 (including as a result of the reinstatement of the HIF for 2020 following the temporary suspension of the HIF for 2019) and expects to continue to request increases in those rates for 2021 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and rating limits, and significant assessments, fees and taxes imposed by the federal and state governments, including as a result of the ACA. The Company's rates also must be adequate to reflect adverse selection in its products, particularly in small group Commercial products. These rate increases may be significant and thus heighten the risks of adverse publicity, adverse regulatory action and adverse selection and the likelihood that the Company's requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

Many of the laws and regulations governing the Company's pricing and underwriting practices also limit the differentials in premium rates insurers and other carriers may charge between new and renewal business, and/or between groups based on differing characteristics. They may also require that carriers disclose to customers the basis on which the carrier establishes new business and renewal premium rates and limit the ability of a carrier to terminate customers' coverage.

Medicaid Regulation - The Company is seeking to substantially grow its Medicaid, dual eligible and dual eligible special needs plan businesses over the next several years. As a result, the Company also is increasing its exposure to changes in government policy with respect to and/or regulation of the various Medicaid, dual eligible and dual eligible special needs plan programs in which the Company participates, including changes in the amounts payable to the Company under those programs.

Since 2017, Managed Medicaid products, including those the Company offers, are subject to a minimum federal MLR of 85%. A Medicaid managed care quality rating system and provider network adequacy requirements also apply to Medicaid products. Because the federal minimum MLR is structured as a "floor," states have the latitude to enact more stringent rules governing these restrictions. For Managed Medicaid products, states may adopt higher minimum MLR requirements, use more stringent definitions of "medical loss ratio" or impose other requirements related to minimum MLR. Minimum MLR requirements and similar actions further limit the level of margin the Company can earn in its Insured Medicaid products while leaving the Company exposed to medical costs that are higher than those reflected in its pricing. The Company also may be subject to significant fines, penalties, premium refunds and litigation if it fails to comply with minimum MLR laws and regulations.

The future of the ACA, and the impact of Medicaid expansion under the ACA, are uncertain. States may opt out of the elements of the ACA requiring expansion of Medicaid coverage without losing their current federal Medicaid funding. To date, a number of states and the District of Columbia have expanded Medicaid coverage to the higher eligibility levels contemplated by the ACA. In addition, the election of new governors and/or state legislatures may impact states' previous decisions regarding Medicaid expansion. Proposals for substantial changes to federal funding of state Medicaid programs are likely to be considered in 2020 and beyond, including the possibility of converting federal Medicaid support to block grants (such as the block grant option outlined by CMS on January 30, 2020) and per capita caps on federal funding. Uncertainty regarding federal funding is causing and will continue to cause states to re-evaluate their Medicaid expansions and consider new assessments, fees and/or taxes on health plans. That re-evaluation and any changes to federal funding of state Medicaid programs may adversely affect Medicaid payment rates, the Company's revenues and its Medicaid membership.

The economic aspects of the Medicaid, dual eligible and dual eligible special needs plan business vary from state to state and are subject to frequent change. Medicaid premiums are paid by each state and differ from state to state. The federal government and certain states also are considering proposals and legislation for Medicaid and dual eligible program reforms or redesigns, including restrictions on the collection of manufacturer's rebates on pharmaceuticals by Medicaid MCOs and their contracted PBMs, further program, population and/or geographic expansions of risk-based managed care, increasing beneficiary cost-sharing or payment levels, and changes to benefits, reimbursement, eligibility criteria, provider network adequacy requirements (including requiring the inclusion of specified high cost providers in the Company's networks) and program structure. In some states, current Medicaid and dual eligible funding and premium revenue may not be adequate for the Company to continue program participation. The Company's Medicaid and dual eligible contracts with states (or sponsors of Medicaid managed care plans) are subject to cancellation by the state (or the sponsors of the managed care plans) after a short notice period without cause (e.g., when a state discontinues a managed care program) or in the event of insufficient state funding.

The Company's Medicaid, dual eligible and dual eligible special needs plan products also are heavily regulated by CMS and state Medicaid agencies, which have the right to audit the Company's performance to determine compliance with CMS contracts and regulations. The Company's Medicaid products, dual eligible products and CHIP contracts also are subject to complex federal and state regulations and oversight by state Medicaid agencies regarding the services provided to Medicaid enrollees, payment for those services, network requirements (including mandatory inclusion of specified high-cost providers), and other aspects of these programs, and by external review organizations which audit Medicaid plans on behalf of state Medicaid agencies. The laws, regulations and contractual requirements applicable to the Company and other participants in Medicaid and dual eligible programs, including requirements that the Company submit encounter data to the applicable state agency, are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and its Medicaid and dual eligible program compliance efforts will continue to require significant resources. CMS and/or state Medicaid agencies may fine the Company, withhold payments to the Company, seek premium and other refunds, terminate the Company's existing contracts, elect not to award the Company new contracts or not to renew the Company's existing contracts, prohibit the Company from continuing to market and/or enroll members in or refuse to automatically assign members to one or more of the Company's Medicaid or dual eligible products, exclude the Company from participating in one or more Medicaid or dual eligible programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS or state regulations or contractual requirements.

The Company cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid program, nor can it predict the impact those changes will have on its business operations or operating results, but the effects could be materially adverse.

Federal and State Reporting - The Company is subject to extensive financial and business reporting requirements, including penalties for inaccuracies and/or omissions, at both the federal and state level. The Company's ability to comply with certain of these requirements depends on receipt of information from third parties that may not be readily available or reliably provided in all instances. The Company is and will continue to be required to modify its information systems, dedicate significant resources

and incur significant expenses to comply with these requirements. However, the Company cannot eliminate the risks of unavailability of or errors in its reports.

Product Design and Administration and Sales Practices - State and/or federal regulatory scrutiny of health care benefit product design and administration and marketing and advertising practices, including the filing of insurance policy forms, the adequacy of provider networks, the accuracy of provider directories, and the adequacy of disclosure regarding products and their administration, is increasing as are the penalties being imposed for inappropriate practices. Medicare, Medicaid and dual eligible products and products offering more limited benefits in particular continue to attract increased regulatory scrutiny.

Guaranty Fund Assessments/Solvency Protection - Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer governed health plans established under the ACA. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that limit future offsets.

Available Information

CVS Health Corporation was incorporated in Delaware in 1996. The corporate office is located at One CVS Drive, Woonsocket, Rhode Island 02895, telephone (401) 765-1500. CVS Health's common stock is listed on the New York Stock Exchange under the trading symbol "CVS." General information about the Company is available through the Company's website at *http://www.cvshealth.com*. The Company's financial press releases and filings with the SEC are available free of charge within the Investors section of the Company's website at *http://investors.cvshealth.com*. In addition, the SEC maintains an internet site that contains reports, proxy and information statements and other information regarding issuers, such as the Company, that file electronically with the SEC. The address of that website is *http://www.sec.gov.* The information on or linked to the Company's website is neither a part of nor incorporated by reference in this 10-K or any of the Company's other SEC filings.

In accordance with guidance provided by the SEC regarding use by a company of its websites and social media channels as a means to disclose material information to investors and to comply with its disclosure obligations under SEC Regulation FD, CVS Health Corporation (the "Registrant") hereby notifies investors, the media and other interested parties that it intends to continue to use its media and investor relations website (*http://investors.cvshealth.com/*) and its Twitter feed (@CVSHealthIR) to publish important information about the Registrant, including information that may be deemed material to investors. The list of social media channels that the Registrant uses may be updated on its media and investor relations website from time to time. The Registrant encourages investors, the media, and other interested parties to review the information the Registrant posts on its website and social media channels as described above, in addition to information announced by the Registrant through its SEC filings, press releases and public conference calls and webcasts.

Item 1A. Risk Factors.

You should carefully consider each of the following risks and uncertainties and all of the other information set forth in this 10-K. These risks and uncertainties and other factors may affect forward-looking statements, including those we make in this 10-K or elsewhere, such as in news releases or investor or analyst calls, meetings or presentations, on our websites or through our social media channels. The risks and uncertainties described below are not the only ones we face. There can be no assurance that we have identified all the risks that affect us. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial also may adversely affect our businesses. Any of these risks or uncertainties could cause our actual results to differ materially from our expectations and the expected results discussed in our forward-looking statements. You should not consider past results to be an indication of future performance.

If any of the following risks or uncertainties develops into actual events or if the circumstances described in the risks or uncertainties occur or continue to occur, those events or circumstances could have a material adverse effect on our businesses, operating results, cash flows, financial condition and/or stock price, among other effects on us. You should read the following section in conjunction with the MD&A, included in Item 7 of this 10-K, our consolidated financial statements and the related notes, included in Item 8 of this 10-K, and our "Cautionary Statement Concerning Forward-Looking Statements" in this 10-K.

Summary

The following is a summary of the principal risks we face:

Risks Related to COVID-19

- The impact of COVID-19 on our businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be material and adverse.
- The impact of COVID-19 and the related testing and vaccination may result in us not being able to accurately forecast health care and other benefit costs, and we are uncertain that future health care and other benefits costs will not exceed our projections.

Risks Relating to Our Businesses

- Each of our segments operates in a highly competitive and evolving business environment.
- A change in our Health Care Benefits product mix may adversely affect our profit margins.
- Negative public perception of the industries in which we operate can adversely affect our businesses, operating results, cash flows and prospects.
- Failure to maintain or improve our relationships with our retail and specialty pharmacy customers may adversely affect our operating results.
- We face risks relating to the availability, pricing and safety profiles of prescription drugs that we purchase and sell.
- We may not be able to accurately forecast health care and other benefit costs.
- If actual claims in our Insured Health Care Benefits products exceed our estimates, our operating results could be materially adversely affected, and our ability to take timely corrective actions to limit future costs may be limited.
- We are exposed to risks relating to the solvency of other insurers.

Risks From Changes in Public Policy and Other Legal and Regulatory Risks

- We are subject to potential changes in public policy, laws and regulations, including reform of the U.S. health care system, which can adversely affect our businesses.
- If we fail to comply with applicable laws and regulations, we could be subject to significant adverse regulatory actions or suffer brand and reputational harm.
- If our compliance or other systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions and/or litigation.
- The litigation and other adverse legal proceedings that we face are costly to defend, may result in changes in our business practices, harm our brand and reputation and adversely affect our businesses and operating results.
- The governmental audits, investigations and reviews to which we are subject could result in changes to our business practices and also could result in material refunds, fines, penalties, civil and/or criminal liabilities and other sanctions.
- Our litigation and regulatory risk profile are changing as we offer new products and services.
- We face unique regulatory and other challenges in our Medicare and Medicaid businesses.
- Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues, and we expect that percentage to increase.
- We may not be able to obtain adequate premium rate increases in our Insured Health Care Benefits products, which would have an adverse effect on our revenues, MBRs and operating results.
- Minimum MLR rebate requirements limit the level of margin we can earn in our Insured Health Care Benefits products while leaving us exposed to higher than expected medical costs.
- Our operating results may be adversely affected by changes in laws and policies governing employers and by union organizing activity.

Risks Associated with Mergers, Acquisitions, and Divestitures

- We may be unable to successfully integrate companies we acquire.

- The acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities we pursue may be unsuccessful.
- In order to complete a proposed acquisition, we may be required to divest certain portions of our business, for which we may not be able to obtain favorable pricing.

Risks Related to Our Operations

- Failure to meet customer expectations may harm our brand and reputation, our ability to retain and grow our customer base and membership and our operating results and cash flows.
- We can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of cyber attacks or other information security (including cybersecurity) risks or threats in the future.
- Our use and disclosure of members', customers' and other constituents' sensitive information is subject to complex regulations at multiple levels, and we would be adversely affected if we or our business associates or other vendors fail to adequately protect members', customers' or other constituents' sensitive information.
- Product liability, product recall or personal injury issues could damage our reputation and have a significant adverse effect on our businesses, operating results, cash flows and/or financial condition.
- We face significant competition in attracting and retaining talented employees, and managing succession for, and retention of, key executives is critical to our success.
- Sales of our products and services are dependent on our ability to attract and motivate internal sales personnel and independent third-party brokers, consultants and agents.
- Failure of our businesses to effectively collaborate could prevent us from maximizing our operating results.
- The failure or disruption of our information technology systems or infrastructure to support our businesses could adversely affect our reputation, businesses, operating results and cash flows.
- Pursuing multiple initiatives simultaneously presents challenges to maintaining, continuing to develop and improve an effective information technology system.
- We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.
- Both our and our vendors' operations are subject to a variety of business continuity hazards and risks.

Financial Risks

- We would be adversely affected if we do not effectively deploy our capital. Downgrades or potential downgrades in our credit ratings could adversely affect our brand and reputation, businesses, operating results, cash flows and financial condition.
- Goodwill and other intangible assets could, in the future, become impaired.
- Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments.
- Our significant indebtedness has increased our consolidated interest expense and could adversely affect our business flexibility and increase our borrowing costs.

Risks Related to Our Relationships with Manufacturers, Providers, Suppliers and Vendors

- We face risks relating to the market availability, pricing, suppliers and safety profiles of prescription drugs and other products that we purchase and sell.
- Our operating results may be adversely affected if we are unable to contract with providers on competitive terms and develop and maintain attractive networks with high quality providers.
- If our service providers fail to meet their contractual obligations to us or to comply with applicable laws or regulations, we may be exposed to brand and reputational harm, litigation and/or regulatory action.
- We may experience increased medical and other benefit costs, litigation risk and customer and member dissatisfaction when providers that do not have contracts with us render services to our Health Care Benefits members.

- Continuing consolidation and integration among providers and other suppliers may increase our medical and other covered benefits costs, make it difficult for us to compete in certain geographies and create new competitors.

Risks Related to COVID-19

The spread of, impact of and response to COVID-19 underscores and amplifies certain risks we face. The impact COVID-19 will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be material and adverse.

COVID-19 has spread to every state in the U.S., has been declared a pandemic by the World Health Organization and has severely impacted, and is expected to continue to severely impact, the economies of the U.S. and other countries around the world.

The legislative and regulatory environment governing our businesses is dynamic and changing frequently, including the Families First Act, the CARES Act and mandated increases to the medical services we must pay for without a corresponding increase in the premiums we receive in our Health Care Benefits Insured products. As a result of COVID-19, including legislative and/or regulatory responses to COVID-19, the premiums we charge in our Insured Health Care Benefits products may prove to be insufficient to cover the cost of medical services delivered to our Insured medical members, which may increase significantly as a result of higher utilization rates of medical facilities and services and other increases in associated hospital and pharmaceutical costs.

Federal, state and local governmental policies and initiatives to reduce the transmission of COVID-19, including shelter-in-place orders and social distancing directives, may not effectively combat the severity and/or duration of the COVID-19 pandemic and have resulted in, among other things, a reduction in utilization that is discretionary, the cancellation of elective medical procedures, reduced customer traffic and front store sales in our retail pharmacies, our customers being ordered to close or severely curtail their operations, the adoption of work-from-home policies and a reduction in diagnostic reporting due to reductions in health care provider visits and restrictions on our access to providers' medical records, all of which impact our businesses. Among other impacts of these policies and initiatives on our businesses, we expect changes in medical claims submission patterns and an adverse impact on (i) drug utilization due to the reduction in discretionary visits with providers; (ii) front store sales as a result of reduced customer traffic in our retail pharmacies due to shelter-in-place orders and COVID-19 related unemployment; (iii) medical membership in our Health Care Benefits segment and covered lives in our PBM clients due to reductions in workforce at our existing customers (including due to business failures) as well as reduced willingness to change benefits providers by prospective customers; (iv) benefit costs due to COVID-19 related support programs we have put in place for our medical members and mandated increases to the medical services we must pay for without a corresponding increase in the premiums we receive in our Insured Health Care Benefits products; and (v) the amount, timing and collectability of payments to the Company from customers, clients, government payers and members as a result of the impact of COVID-19 on them. Over time, these policies and initiatives also may cause us to experience increased benefit costs and/or decreased revenues in our Health Care Benefits segment if, as a result of our medical members not seeing their providers as a result of COVID-19, we are unable to implement clinical initiatives to manage benefit costs and chronic conditions of our medical members and appropriately document their risk profiles.

In addition, in response to COVID-19, during the first half of 2020, we began to offer our medical members expanded benefit coverage and became obligated by governmental action to provide other additional coverage. This expanded benefit coverage is being provided without a corresponding increase in the premiums we receive in our Insured Health Care Benefits products. We also are taking actions designed to help provide financial and administrative relief for the health care provider community. Such measures and any further steps we take or are required to take to expand or otherwise modify the services delivered to our Health Care Benefits members, provide relief for the health care provider community, or in connection with the relaxation of shelter-in-place orders and social distancing directives and other restrictions on movement and economic activity intended to reduce the spread of COVID-19, including the potential for widespread testing and vaccination, as a component of lifting those measures, could adversely impact our benefit costs, MBR and operating results.

The various initiatives we have implemented to slow and/or reduce the impact of COVID-19, such as colleagues working remotely and installing protective equipment in our retail pharmacies, and the COVID-19-related support programs we have put in place for our customers, medical members and colleagues have increased our operating expenses and reduced the efficiency of our operations. Our operating results will continue to be adversely affected so long as these initiatives continue or if they are expanded. In addition, the adverse economic conditions in the U.S.

and abroad caused by COVID-19 have had, and may continue to have, an adverse impact on our net investment income and the value of our investment portfolio.

The spread of COVID-19, or actions taken to mitigate its spread, could have material and adverse effects on our ability to operate our businesses effectively, including as a result of the complete or partial closure of facilities, labor shortages and/or financial difficulties experienced by third-party service providers. Disruptions in our supply chains, our distribution chains and/

or public and private infrastructure, including communications and financial services, could materially and adversely impact our business operations. We have transitioned a significant subset of our colleagues to a remote work environment in an effort to mitigate the spread of COVID-19, as have a significant number of our third-party service providers, which may amplify certain risks to our businesses, including an increased demand for information technology resources, increased risk of phishing and other cybersecurity attacks, increased risk of unauthorized dissemination of sensitive personal information or proprietary or confidential information about us or our medical members or other third-parties and increased risk of business interruptions.

While the FDA has authorized some COVID-19 vaccines for emergency use, the COVID-19 pandemic continues to evolve and the severity and duration of the pandemic and scope and intensity of the governmental response to it are unknown at this time. We believe COVID-19's impact on our businesses, operating results, cash flows and/or financial condition primarily will be driven by the geographies impacted and the severity and duration of the pandemic; the pandemic's impact on the U.S. and global economies and consumer behavior and health care utilization patterns; and the timing, scope and impact of stimulus legislation as well as other federal, state and local governmental responses to the pandemic. Those primary drivers are beyond our knowledge and control. As a result, the impact COVID-19 will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be adverse and material. COVID-19 also may result in legal and regulatory proceedings, investigations and claims against us.

A number of factors, many of which are beyond our control, including COVID-19 and related testing and vaccination, contribute to rising health care and other benefit costs. We may not be able to accurately forecast health care and other benefit costs, which could adversely affect our Health Care Benefits segment's operating results. There can be no assurance that future health care and other benefits costs will not exceed our projections.

As a result of COVID-19, the current economic environment is adverse and less predictable than recently experienced, which has caused and may continue to cause unanticipated and significant volatility in our health care and other benefits costs, including COVID-19 related testing and vaccination and post-acute care skilled nursing facility and behavioral health costs. On January 21, 2021, the President of the United States issued an executive order to support government efforts to expand access, availability and use of COVID-19 diagnostic, screening and surveillance and addressed the cost of COVID-19 testing by facilitating COVID-19 testing free of charge to those who lack comprehensive health insurance and clarifying group health plans' and health insurance issuers' obligations to provide coverage for COVID-19 testing. In addition, the timing of vaccine administration to the general public and related costs as well as the identification of new, more infectious strains of the COVID-19 virus and whether the vaccines will be effective against such new strains are uncertain and may impact our MBR. Premiums for our Insured Health Care Benefits products, which comprised 92% of our Health Care Benefits revenues for 2020, are priced in advance based on our forecasts of health care and other benefit costs during a fixed premium period, which is generally twelve months. These forecasts are typically developed several months before the fixed premium period begins, are influenced by historical data (and recent historical data in particular), are dependent on our ability to anticipate and detect medical cost trends and changes in our members' behavior and health care utilization patterns and medical claim submission patterns and require a significant degree of judgment. For example, our revenue on Medicare policies is based on bids submitted in June of the year before the contract year. Cost increases in excess of our projections cannot be recovered in the fixed premium period through higher premiums. As a result, our profits are particularly sensitive to the accuracy of our forecasts of the increases in health care and other benefit costs that we expect to occur and our ability to anticipate and detect medical cost trends. For 2021, those forecasts include adjustments made to pricing based on prospective expectations for liabilities due to testing, vaccines, direct COVID-19 treatment and deferred care. Risk-adjusted revenue has been adjusted for deferred care, and forecasted enrollment considers assumptions about the economic environment, though COVID-19 related impacts remain uncertain. During periods such as 2020 and 2021 when health care and other benefit costs, utilization and/or medical costs trends experience significant volatility and medical claim submission patterns are changing rapidly as a result of COVID-19, accurately detecting, forecasting, managing, reserving and pricing for our (and our self-insured customers') medical cost trends and incurred and future health care and other benefits costs is more challenging. There can be no assurance regarding the accuracy of the health care or other benefit cost projections reflected in our pricing, and our health care and other benefit costs (including COVID-19 related testing and vaccination and post-acute care skilled nursing facility and behavioral health costs) are affected by COVID-19 and other external events over which we have no control. Even relatively small differences between predicted and actual health care and other benefit costs as a percentage of premium revenues can result in significant adverse changes in our Health Care Benefits segment's operating results.

A number of factors contribute to rising health care and other benefit costs, including COVID-19, previously uninsured members entering the health care system, changes in members' behavior and health care utilization patterns, turnover in our membership, additional government mandated benefits or other regulatory changes (including under the Families First Act and the CARES Act), changes in the health status of our members, the aging of the population and other changing demographic characteristics, advances in medical technology, increases in the number and cost of prescription drugs (including specialty

pharmacy drugs and ultra-high cost drugs and therapies), direct-to-consumer marketing by drug manufacturers, the increasing influence of social media on our members' health care utilization and other behaviors, changes in health care practices and general economic conditions (such as inflation and employment levels). In addition, government-imposed limitations on Medicare and Medicaid reimbursements to health plans and providers have caused the private sector to bear a greater share of increasing health care and other benefits costs over time, and future amendments or repeal or replacement of the ACA that increase the uninsured population may amplify this problem. Other factors that affect our health care and other benefit costs include epidemics or other pandemics, changes as a result of the ACA, changes to or the discontinuation of the ACA and other changes in the regulatory environment, the evolution toward a consumer driven business model, new technologies, influenza-related health care costs (which may be substantial), clusters of high-cost cases, health care provider and member fraud, and numerous other factors that are or may be beyond our control.

Furthermore, if we are not able to accurately and promptly anticipate and detect medical cost trends or accurately estimate the cost of incurred but not yet reported claims or reported claims that have not been paid, our ability to take timely corrective actions to limit future health care costs and reflect our current benefit cost experience in our pricing process may be limited, which would further amplify the extent of any adverse impact on our operating results. These risks are particularly acute during periods such as 2020 and 2021 when health care and other benefit costs, utilization and/or medical cost trends experience significant volatility and medical claim submission patterns are changing rapidly as a result of COVID-19. Such risks are further magnified by the ACA and other existing and future legislation and regulations that limit our ability to price for our projected and/or experienced increases in utilization and/or medical cost trends.

There can be no assurance that future health care and other benefits costs will not exceed our projections.

Adverse economic conditions in the U.S. and abroad can materially and adversely impact our businesses, operating results, cash flows and financial condition, and we do not expect these conditions to improve in the near future.

The COVID-19 pandemic, the availability and cost of credit and other capital, higher unemployment rates and other factors have contributed to adverse conditions in the global economy and significantly diminished expectations for the global economy, and particularly the U.S. economy, at least through the end of 2020 and possibly longer. Our customers, medical providers and the other companies with which we do business are generally headquartered in the U.S.; however, many of our largest customers are global companies with operations around the world. As a result, adverse economic conditions in the U.S. and abroad, including those caused by COVID-19, can materially and adversely impact our businesses, operating results, cash flows and financial condition, including:

- In our Pharmacy Services segment, by causing drug utilization to decline, reducing demand for PBM services and adversely affecting the financial health of our PBM clients.
- In our Retail/LTC segment, by causing drug utilization to decline, changing consumer purchasing power, preferences and/or spending patterns leading to reduced consumer demand for products sold in our stores and adversely affecting the financial health of our LTC pharmacy customers.
- By causing our existing customers to reduce workforces (including due to business failures), which would reduce our revenues, the number of covered lives in our PBM clients and/or the number of members our Health Care Benefits segment serves.
- By causing our clients and customers and potential clients and customers, particularly those with the most employees or members, and state and local governments, to force us to compete more vigorously on factors such as price and service, including service, discount and other performance guarantees, to retain or obtain their business.
- By causing customers and potential customers of our Retail/LTC and Health Care Benefits segments to purchase fewer products and/or products that generate less profit for us than the ones they currently purchase or otherwise would have purchased.
- By causing customers and potential customers of our Health Care Benefits segment, particularly smaller employers and individuals, to forego obtaining or renewing their health and other coverage with us.
- In our Health Care Benefits segment, by causing unanticipated increases and volatility in utilization of medical and other covered services, including COVID-19 related testing, vaccination and behavioral health services,

by our medical members, changes in medical claim submission patterns and/or increases in medical unit costs and/or provider behavior, each of which would increase our costs and limit our ability to accurately detect, forecast, manage, reserve and price for our (and our self-insured customers') medical cost trends and incurred and future health care and other benefits costs.

- By increasing medical unit costs and causing changes in provider behavior in our Health Care Benefits segment as hospitals and other providers attempt to maintain revenue levels in their efforts to adjust to their own COVID-19-related and other economic challenges.
- By weakening the ability or perceived ability of the issuers and/or guarantors of the debt or other securities we hold in our investment portfolio to perform on their obligations to us, which could result in defaults in those securities and has reduced, and may further reduce, the value of those securities and has created, and may continue to create, net realized capital losses for us that reduce our operating results.
- By weakening the ability of our customers, including self-insured customers in our Health Care Benefits segment, medical providers and the other companies with which we do business as well as our medical members to perform their obligations to us or causing them not to perform those obligations, either of which could reduce our operating results.
- By weakening the ability of our former subsidiaries and/or their purchasers to satisfy their lease obligations that we have guaranteed and causing the Company to be required to satisfy those obligations.
- By weakening the financial condition of other insurers, including long-term care insurers and life insurers, which increases the risk that we will receive significant assessments for obligations of insolvent insurers to policyholders and claimants.
- By causing, over time, inflation that could cause interest rates to increase and thereby increase our interest expense and reduce our operating results, as well as decrease the value of the debt securities we hold in our investment portfolio, which would reduce our operating results and/or adversely affect our financial condition.

Furthermore, reductions in workforce by our customers can cause unanticipated increases in the health care and other benefits costs of our Health Care Benefits segment. For example, our business associated with members who have elected to receive benefits under Consolidated Omnibus Budget Reconciliation Act (known as "COBRA") typically has an MBR that is significantly higher than our overall Commercial MBR.

Risks Relating to Our Businesses

Each of our segments operates in a highly competitive and evolving business environment; and gross margins in the industries in which we compete may decline.

Each of our segments, Pharmacy Services, which includes our pharmacy benefit management ("PBM") business, Retail/LTC, and Health Care Benefits, operates in a highly competitive and evolving business environment. Specifically:

- As competition increases in the geographies in which we operate, including competition from new entrants, a significant increase in price compression and/or reimbursement pressures could occur, and this could require us to reevaluate our pricing structures to remain competitive.
- The competitive success of our Pharmacy Services segment is dependent on our ability to establish and maintain contractual relationships with network pharmacies as PBM clients evaluate adopting narrow or restricted retail pharmacy networks.
- The competitive success of our Retail/LTC segment and our specialty pharmacy operations is dependent on our ability to establish and maintain contractual relationships with PBMs and other payors on acceptable terms as the payors' clients evaluate adopting narrow or restricted retail pharmacy networks.
- In our PBM business, we maintain contractual relationships with brand name drug manufacturers that provide for purchase discounts and/or rebates on drugs dispensed by pharmacies in our retail network and by our specialty and mail order pharmacies (all or a portion of which may be passed on to clients). Manufacturer's rebates often depend on a PBM's ability to meet contractual requirements, including the placement of a manufacturer's products on the PBM's formularies. If we lose our relationship with one or more drug manufacturers, or if the discounts or rebates provided by drug manufacturers decline, our operating results, cash flows and/or prospects could be adversely affected.
- The PBM industry has been experiencing price compression as a result of competitive pressures and increased client demands for lower prices, increased revenue sharing, including sharing in a larger portion of rebates received from drug manufacturers, enhanced service offerings and/or higher service levels. Marketplace dynamics and regulatory changes also have adversely affected our ability to offer plan sponsors pricing that includes the use of

retail “differential” or “spread,” which could adversely affect our future profitability, and we expect these trends to continue.

- Our retail pharmacy, specialty pharmacy and LTC pharmacy operations have been affected by reimbursement pressure caused by competition, including client demands for lower prices, generic drug pricing, earlier than expected generic drug introductions and network reimbursement pressure. If we are unable to increase our prices to reflect, or otherwise mitigate

the impact of, increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose customers to competitors with more favorable pricing, adversely affecting our revenues and operating results.

- A shift in the mix of our pharmacy prescription volume towards programs offering lower reimbursement rates as a result of competition or otherwise could adversely affect our margins, including the ongoing shift in pharmacy mix towards 90-day prescriptions at retail and the ongoing shift in pharmacy mix towards Medicare Part D prescriptions.
- PBM client contracts often are for a period of approximately three years. However, PBM clients may require early or periodic re-negotiation of pricing prior to contract expiration. PBM clients are generally well informed, can move between us and our competitors and often seek competing bids prior to expiration of their contracts. We are therefore under pressure to contain price increases despite being faced with increasing drug costs and increasing operating costs. If we are unable to increase our prices to reflect, or otherwise mitigate the impact of, increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose customers to competitors with more favorable pricing, adversely affecting our revenues and operating results.
- The operating results and margins of our LTC business are further affected by the increased efforts of health care payors to negotiate reduced or capitated pricing arrangements and by the financial health of, and purchases and sales of, our LTC customers.
- In our Health Care Benefits segment we are seeking to substantially grow our Medicaid, dual eligible and dual eligible special needs plan membership over the next several years. In many instances, to acquire and retain our government customers' business, we must bid against our competitors in a highly competitive environment. Winning bids often are challenged successfully by unsuccessful bidders, and may also be withdrawn or cancelled by the issuing agency.
- Customer contracts in our Health Care Benefits segment are generally for a period of one year, and our customers have considerable flexibility in moving between us and our competitors. One of the key factors on which we compete for customers, especially in uncertain economic environments, is overall cost. We are therefore under pressure to contain premium price increases despite being faced with increasing health care and other benefit costs and increasing operating costs. If we are unable to increase our prices to reflect, or otherwise mitigate the impact of, increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose members to competitors with more favorable pricing, adversely affecting our revenues and operating results. In response to rising prices, our customers may elect to self-insure or to reduce benefits in order to limit increases in their benefit costs. Alternatively, our customers may purchase different types of products from us that are less profitable. Such elections may result in reduced membership in our more profitable Insured products and/or lower premiums for our Insured products, which may adversely affect our revenues and operating results, although such elections also may reduce our health care and other benefit costs. In addition, our Medicare, Medicaid and CHIP products are subject to termination without cause, periodic re-bid, rate adjustment and program redesign, as customers seek to contain their benefit costs, particularly in an uncertain economy, and our exposure to this risk is increasing as we grow our Government products membership. These actions may adversely affect our membership, revenues and operating results.
- We requested increases in our premium rates in our Commercial Health Care Benefits business for 2021 and expect to continue to request increases in those rates for 2022 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and rating limits, and significant assessments, fees and taxes imposed by federal and state governments, including as a result of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA"). Our rates also must be adequate to reflect the risk that our products will be selected by people with a higher risk profile or utilization rate than the pool of participants we anticipated when we established pricing for the applicable products (also known as "adverse selection"), particularly in small group Commercial products. These rate increases may be significant and thus heighten the risks of adverse publicity, adverse regulatory action and adverse selection and the likelihood that our requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

In addition, competitors in each of our businesses may offer services and pricing terms that we may not be willing or able to offer. Competition also may come from new entrants and other sources in the future. Unless we can demonstrate enhanced value to our clients through innovative product and service offerings in the rapidly changing health care industry, we may be unable to remain competitive.

Disruptive innovation by existing or new competitors could alter the competitive landscape in the future and require us to accurately identify and assess such alterations and make timely and effective changes to our strategies and business model to compete effectively. For example, decisions to buy our Pharmacy Services and Health Care Benefits products and services increasingly are made or influenced by consumers, either through direct purchasing (e.g., Medicare Advantage plans and PDPs) or through public health insurance exchanges ("Public Exchanges") and private health insurance exchanges (together with Public Exchanges, collectively, "Insurance Exchanges") that allow individual choice. Consumers also are increasingly seeking to access consumer goods and health care products and services locally and through other direct channels such as mobile

devices and websites. To compete effectively in the consumer-driven marketplace, we will be required to develop or acquire new capabilities, attract new talent and develop new service and distribution relationships that respond to consumer needs and preferences.

Changes in marketplace dynamics or the actions of competitors or manufacturers, including industry consolidation, the emergence of new competitors and strategic alliances, and decisions to exclude us from new narrow or restricted retail pharmacy networks could materially and adversely affect our businesses, operating results, cash flows and/or prospects.

A change in our Health Care Benefits product mix may adversely affect our profit margins.

Our Insured Health Care Benefits products that involve greater potential risk generally tend to be more profitable than our ASC products. Historically, smaller employer groups have been more likely to purchase Insured Health Care Benefits products because such purchasers are generally unable or unwilling to bear greater liability for health care expenditures, although over the last several years even relatively small employers have moved to ASC products. We also serve, and expect to grow our business with, government-sponsored programs, including Medicare and Medicaid, that are subject to competitive bids and have lower profit margins than our Commercial Insured Health Care Benefits products. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on the Health Care Benefits segment's operating results.

Negative public perception of the industries in which we operate, or of our industries' or our practices, can adversely affect our businesses, operating results, cash flows and prospects.

Our brand and reputation are two of our most important assets, and the industries in which we operate have been and are negatively perceived by the public from time to time. Negative publicity may come as a result of adverse media coverage, litigation against us and other industry participants, the ongoing public debates over drug pricing, PBMs, government involvement in drug pricing and purchasing, the future of the ACA, "surprise" medical bills, governmental hearings and/or investigations, actual or perceived shortfalls regarding our industries' or our own products and/or business practices (including PBM operations, drug pricing and insurance coverage determinations) and social media and other media relations activities. Negative publicity also may come from a failure to meet customer expectations for consistent, high quality and accessible care. This risk may increase as we continue to offer products and services that make greater use of data and as our business model becomes more focused on delivering health care to consumers.

In addition, by working with the U.S. government in the distribution and administration of the COVID-19 vaccine, the Company may be subject to negative publicity related to the government's actions in response to COVID-19 that are outside of the ability of the Company to control.

Negative public perception and/or publicity of our industries in general, or of us or our key vendors, brokers or product distribution networks in particular, can further increase our costs of doing business and adversely affect our operating results and our stock price by:

- adversely affecting our brand and reputation;
- adversely affecting our ability to market and sell our products and/or services and/or retain our existing customers and members;
- requiring us to change our products and/or services;
- reducing or restricting the revenue we can receive for our products and/or services; and/or
- increasing or significantly changing the regulatory and legislative requirements with which we must comply.

We must maintain and improve our relationships with our retail and specialty pharmacy customers and increase the demand for our products and services, including proprietary brands.

The success of our businesses depends in part on customer loyalty, superior customer service and our ability to persuade customers to frequent our retail stores and online sites and to purchase products in additional categories and our proprietary brands. Failure to timely identify or effectively respond to changing consumer preferences and spending patterns, and evolving demographic mixes in the communities we serve, an inability to expand the products

being purchased by our clients and customers, or the failure or inability to obtain or offer particular categories of products could adversely affect our relationship with our customers and clients and the demand for our products and services and could result in excess inventories of products.

We offer our retail customers proprietary brand products that are available exclusively at our retail stores and through our online retail sites. The sale of proprietary products subjects us to unique risks including potential product liability risks, mandatory or voluntary product recalls, potential supply chain and distribution chain disruptions for raw materials and finished products, our ability to successfully protect our intellectual property rights and the rights of applicable third parties, and other risks generally encountered by entities that source, market and sell private-label products. We also face similar risks for the other products we sell in our retail operations, including supply chain and distribution chain disruption risk. Any failure to adequately address some or all of these risks could have an adverse effect on our retail business, operating results, cash flows and/or financial condition. Additionally, an increase in the sales of our proprietary brands may adversely affect our sales of products owned by our suppliers and adversely impact certain of our supplier relationships. Our ability to locate qualified, economically stable suppliers who satisfy our requirements, and to acquire sufficient products in a timely and effective manner, is critical to ensuring, among other things, that customer confidence is not diminished. Any failure to develop sourcing relationships with a broad and deep supplier base could adversely affect our operating results and erode customer loyalty.

We also could be adversely affected if we fail to identify or effectively respond to changes in marketplace dynamics. For example, specialty pharmacy represents a significant and growing proportion of prescription drug spending in the U.S., a significant portion of which is dispensed outside of traditional retail pharmacies. Because our specialty pharmacy business focuses on complex and high-cost medications, many of which are made available by manufacturers to a limited number of pharmacies (so-called limited distribution drugs) that serve a relatively limited universe of patients, the future growth of our specialty pharmacy business depends largely upon expanding our access to key drugs and penetration in certain treatment categories. Any contraction of our base of patients or reduction in demand for the prescriptions we currently dispense could have an adverse effect on our specialty pharmacy business, operating results and cash flows.

We face risks relating to the availability, pricing and safety profiles of prescription drugs that we purchase and sell.

The profitability of our Retail/LTC and Pharmacy Services segments is dependent upon the utilization of prescription drug products. We dispense significant volumes of brand name and generic drugs from our retail, LTC, specialty and mail order pharmacies, and the retail pharmacies in our PBM's network also dispense significant volumes of brand name and generic drugs. Our revenues, operating results and cash flows may decline if physicians cease writing prescriptions for drugs or the utilization of drugs is reduced, including due to:

- increased safety risk profiles or regulatory restrictions;
- manufacturing or other supply issues;
- certain products being withdrawn by their manufacturers or transitioned to over-the-counter products;
- future FDA rulings restricting the supply or increasing the cost of products;
- the introduction of new and successful prescription drugs or lower-priced generic alternatives to existing brand name products; or
- inflation in the price of brand name drugs.

In addition, increased utilization of generic drugs (which normally yield a higher gross profit rate than equivalent brand name drugs) has resulted in pressure to decrease reimbursement payments to retail, mail order, specialty and LTC pharmacies for generic drugs, causing a reduction in our margins on sales of generic drugs. Consolidation within the generic drug manufacturing industry and other external factors may enhance the ability of manufacturers to sustain or increase pricing of generic drugs and diminish our ability to negotiate reduced generic drug acquisition costs. Any inability to offset increased brand name or generic prescription drug acquisition costs or to modify our activities to lessen the financial impact of such increased costs could have a significant adverse effect on our operating results.

A number of factors, many of which are beyond our control, contribute to rising health care and other benefit costs. We may not be able to accurately forecast health care and other benefit costs, which could adversely affect our Health Care Benefits segment's operating results.

Premiums for our Insured Health Care Benefits products, which comprised 92% of our Health Care Benefits revenues for 2020, are priced in advance based on our forecasts of health care and other benefit costs during a fixed

premium period, which is generally one year. These forecasts are typically developed several months before the fixed premium period begins, are influenced by historical data (and recent historical data in particular), are dependent on our ability to anticipate and detect medical cost trends and changes in our members' behavior and health care utilization patterns and require a significant degree of judgment. For example, our revenue on Medicare policies is based on bids submitted in June of the year before the contract year. Cost increases in excess of our projections cannot be recovered in the fixed premium period through higher premiums. As

a result, our profits are particularly sensitive to the accuracy of our forecasts and our ability to anticipate and detect medical cost trends. Even relatively small differences between predicted and actual health care and other benefit costs as a percentage of premium revenues can result in significant adverse changes in our operating results.

A number of factors contribute to rising health care and other benefit costs, including previously uninsured members entering the health care system, changes in members' behavior and health care utilization patterns, turnover in our membership, additional government mandated benefits or other regulatory changes, changes in the health status of our members, the aging of the population and other changing demographic characteristics, advances in medical technology, increases in the number and cost of prescription drugs (including specialty pharmacy drugs and ultra-high cost drugs and therapies), direct-to-consumer marketing by drug manufacturers, the increasing influence of social media on our members' health care utilization and other behaviors, changes in health care practices and general economic conditions (such as inflation and employment levels). In addition, government-imposed limitations on Medicare and Medicaid reimbursements to health plans and providers have caused the private sector to bear a greater share of increasing health care and other benefits costs over time, and future amendments or repeal or replacement of the ACA that increase the uninsured population may exacerbate this problem. Other factors that affect our health care and other benefit costs include changes as a result of the ACA, changes to the ACA and other changes in the regulatory environment, the evolution toward a consumer driven business model, new technologies, influenza related health care costs (which may be substantial and higher than we project), clusters of high-cost cases, epidemics or pandemics, health care provider and member fraud, and numerous other factors that are or may be beyond our control. For example, the 2020-2021 influenza season was impacted by efforts taken to reduce the spread of COVID-19; and the 2019-2020 influenza season had an earlier than average start and had a higher incidence of influenza than the 2018-2019 influenza season.

Our Health Care Benefits segment's operating results and competitiveness depend in large part on our ability to appropriately manage future health care and other benefit costs through underwriting criteria, product design, provider network configuration, negotiation of favorable provider contracts and medical management programs. Our medical cost management programs may not be successful and may have a smaller impact on health care and benefit costs than we expect. The factors described above may adversely affect our ability to predict and manage health care and other benefit costs, which can adversely affect our competitiveness and operating results.

The reserves we hold for expected claims in our Insured Health Care Benefits products are based on estimates that involve an extensive degree of judgment and are inherently variable. Any reserve, including a premium deficiency reserve, may be insufficient. If actual claims exceed our estimates, our operating results could be materially adversely affected, and our ability to take timely corrective actions to limit future costs may be limited.

A large portion of health care claims are not submitted to us until after the end of the quarter in which services are rendered by providers to our members. Our reported health care costs payable for any particular period reflect our estimates of the ultimate cost of such claims as well as claims that have been reported to us but not yet paid. We also must estimate the amount of rebates payable under the MLR rules of the ACA, CMS and the OPM and the amounts payable by us to, and receivable by us from, the United States federal government under the ACA's remaining premium stabilization program.

Our estimates of health care costs payable are based on a number of factors, including those derived from historical claim experience, but this estimation process also makes use of extensive judgment. Considerable variability is inherent in such estimates, and the accuracy of the estimates is highly sensitive to changes in medical claims submission and processing patterns and/or procedures, turnover and other changes in membership, changes in product mix, changes in the utilization of medical and/or other covered services, including prescription drugs, changes in medical cost trends, changes in our medical management practices and the introduction of new benefits and products. We estimate health care costs payable periodically, and any resulting adjustments, including premium deficiency reserves, are reflected in current-period operating results within benefit costs. For example, as of December 31, 2020 and 2019, we established a premium deficiency reserve of $11 million and $4 million, respectively, related to Medicaid products in the Health Care Benefits segment. A worsening (or improvement) of health care cost trend rates or changes in claim payment patterns from those that we assumed in estimating health care costs payable as of December 31, 2020 would cause these estimates to change in the near term, and such a change could be material.

Furthermore, if we are not able to accurately and promptly anticipate and detect medical cost trends or accurately estimate the cost of incurred but not yet reported claims or reported claims that have not been paid, our ability to take timely corrective actions to limit future health care costs and reflect our current benefit cost experience in our pricing process may be limited, which would further exacerbate the extent of any adverse impact on our operating results. These risks are particularly acute during and following periods when utilization of medical and/or other covered services and/or medical cost trends are below recent historical levels and in products where there is significant turnover in our membership each year, and such risks are

further magnified by the ACA and other legislation and regulations that limit our ability to price for our projected and/or experienced increases in utilization and/or medical cost trends.

Our operating results are affected by the health of the economy in general and in the geographies we serve.

Our businesses are affected by the U.S. economy and consumer confidence in general and in the geographies we serve, including various economic factors, including inflation and changes in consumer purchasing power, preferences and/or spending patterns. An unfavorable, uncertain or volatile economic environment could cause a decline in drug utilization, an increase in health care utilization and dampen demand for PBM services as well as consumer demand for products sold in our retail stores.

If our customers' operating and financial performance deteriorates, or they are unable to make scheduled payments or obtain adequate financing, our customers may not be able to pay timely, or may delay payment of, amounts owed to us. Any inability of our customers to pay us for our products and services may adversely affect our businesses, operating results and cash flows. In addition, both state and federal government sponsored payers, as a result of budget deficits or spending reductions, may suspend payments or seek to reduce their health care expenditures resulting in our customers delaying payments to us or renegotiating their contracts with us.

Further, economic conditions including interest rate fluctuations, changes in capital market conditions and regulatory changes may affect our ability to obtain necessary financing on acceptable terms, our ability to secure suitable store locations under acceptable terms, our ability to execute sale-leaseback transactions under acceptable terms and the value of our investment portfolio. Adverse changes in the U.S. economy, consumer confidence and economic conditions could have an adverse effect on our businesses and financial results. This adverse effect could be further exacerbated by the increasing prevalence of high deductible health plans and health plan designs favoring co-insurance over co-payments as members and other consumers may decide to postpone, or not to seek, medical treatment which may lead them to incur more expensive medical treatment in the future and/or decrease our prescription volumes.

In addition, our Health Care Benefits membership remains concentrated in certain U.S. geographies and in certain industries. Unfavorable changes in health care or other benefit costs or reimbursement rates or increased competition in those geographic areas where our membership is concentrated could therefore have a disproportionately adverse effect on our Health Care Benefits segment's operating results. Our Health Care Benefits membership has been and may continue to be affected by workforce reductions by our customers due to adverse and/or uncertain general economic conditions, especially in the U.S. geographies and industries where our membership is concentrated. As a result, we may not be able to profitably grow and diversify our Health Care Benefits membership geographically, by product type or by customer industry, and our revenues and operating results may be disproportionately affected by adverse changes affecting our customers.

We are exposed to risks relating to the solvency of other insurers.

We are subject to assessments under guaranty fund laws existing in all states for obligations of insolvent insurance companies (including long-term care insurers), HMOs, ACA co-ops and other payors to policyholders and claimants. For example, in the first quarter of 2017, Aetna recorded a discounted estimated liability expense of $231 million pretax for our estimated share of future assessments for long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries. Guaranty funds are maintained by state insurance commissioners to protect policyholders and claimants in the event that an insurer, HMO, ACA co-op and/or other payor becomes insolvent or is unable to meet its financial obligations. These funds are usually financed by assessments against insurers regulated by a state. Future assessments may have an adverse effect on our operating results and cash flows.

Extreme events, or the threat of extreme events, could materially increase our health care (including behavioral health) costs.

Nuclear, biological or other attacks, whether as a result of war or terrorism, other man-made disasters, natural disasters, epidemics, pandemics and other extreme events can affect the U.S. economy in general, our industries and us specifically. In particular, such extreme events or the threat of such extreme events could result in significant health care (including behavioral health) costs, which also would be affected by the government's actions and the responsiveness of public health agencies and other insurers. Such extreme events or the threat of such extreme events

also could disrupt our supply chains and/or our distribution chains for the products we sell. In addition, our employees and those of our vendors are concentrated in certain large, metropolitan areas which may be particularly exposed to these events. Such events could adversely affect our businesses,

operating results and cash flows, and, in the event of extreme circumstances, our financial condition or viability, particularly if our responses to such events are less adequate than those of our competitors.

Risks From Changes in Public Policy and Other Legal and Regulatory Risks

We are subject to potential changes in public policy, laws and regulations, including reform of the U.S. health care system, which can adversely affect our businesses. Entitlement program reform, if it occurs, could have a material adverse effect on our businesses, operations and/or operating results.

The political environment in which we operate remains uncertain. It is reasonably possible that our business operations and operating results could be materially adversely affected by legislative, regulatory and public policy changes at the federal or state level, increased government involvement in drug reimbursement, pricing, purchasing and/or importation and/or increased regulation of PBMs, including: changes to the Medicare or Medicaid programs (including the block grant option outlined by CMS on January 30, 2020, the "block grant option") or the regulatory environment for health care and related benefits, including the ACA; changes to laws or regulations governing drug reimbursement and/or pricing; changes to the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs; changes to laws and/or regulations governing drug manufacturers' rebates; changes to laws and/or regulations governing reimbursements paid to pharmacists by and/or reporting required by PBMs; changes to immigration policies and/or other public policy initiatives. It is not possible to predict whether or when any such changes will occur or what form any such changes may take (including through the use of U.S. Presidential Executive Orders). Other significant changes to health care and related benefits system legislation or regulation as well as changes with respect to tax and trade policies, tariffs and other government regulations affecting trade between the United States and other countries also are possible and could adversely affect our businesses. If we fail to respond adequately to such changes, including by implementing strategic and operational initiatives, or do not respond as effectively as our competitors, our businesses, operations and operating results may be materially adversely affected.

In addition to efforts to amend, repeal or replace the ACA and related regulations, we expect the federal and state governments to continue to enact and seriously consider many broad-based legislative and regulatory proposals that will or could materially impact various aspects of the health care and related benefits system and our businesses. Potential modification to the ACA, including changes in enforcement and/or funding that further destabilize the Public Exchanges, as well as significant changes to Medicaid funding (including the block grant option) could impact the number of Americans with health insurance and, consequently, prescription drug coverage. Further changes to federal health care and related benefits laws, including the ACA, drug reimbursement and pricing laws, laws governing PBMs and/or laws governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, are probable. We cannot predict the effect, if any, that new health care and related benefits legislation, future changes to the ACA or the implementation of or failure to implement the outstanding provisions of ACA, may have on our Pharmacy Services, retail pharmacy, LTC pharmacy and/or Health Care Benefits operations and/or operating results. The federal and many state governments also are considering changes in the interpretation, enforcement and/or application of existing programs, laws and regulations, including changes to payments under and funding of Medicare and Medicaid programs and increased regulation of PBMs.

Further, changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to additional regulation of PBMs (including formulary management or other PBM services), drug pricing or purchasing, patent term extensions and/or purchase discount and/or rebate arrangements with drug manufacturers also could reduce the discounts or rebates we receive. Changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to claims processing and billing, including our ability to use MAC lists and collect transmission fees, also could adversely affect our profitability. For example, on October 29, 2020, the HHS released a final rule requiring health insurers to disclose drug pricing and cost-sharing information. The final rule requires group health plans and health insurance issuers in the individual and group markets to disclose cost-sharing information upon request, to a participant, beneficiary, or enrollee, which, unless otherwise indicated, for the purpose of the final rules includes an authorized representative, and requires plans and issuers to disclose in-network provider rates, historical out-of-network allowed amounts and the associated billed charges, and negotiated rates for prescription drugs. The public disclosure of insurer- or PBM-negotiated price concessions may result in drug manufacturers lowering discounts or rebates, resulting in higher drug costs for patients and impacting the ability of the Company to negotiate drug prices and provide competitive products and services to consumers.

In addition, in November 2020, the HHS released the Rebate Rule, which eliminates the regulatory safe harbor from prosecution under the AKS for rebates from pharmaceutical companies to PBMs in Medicare Part D and in Medicaid MCOs, replacing it with two far narrower safe harbors designed to directly benefit patients with high out-of-pocket costs and to change the way PBMs are compensated. The new safe harbors are (i) for rebates which are passed on to the patient at the point of sale

and (ii) for flat service fee payments made to PBMs which cannot be tied to the list prices of drugs. The PCMA, which represents PBMs, has filed a suit in an effort to block the Rebate Rule, claiming that the Rebate Rule would lead to higher premiums in Medicare Part D and was adopted in an unlawful manner. It is unclear whether the Rebate Rule will be enforceable, whether pharmaceutical companies will respond by reducing list prices, whether list prices in the private market may also be reduced, and what the resulting impact will be to PBMs or the Company.

We cannot predict the enactment or content of new legislation or regulations or changes to existing laws or regulations or their enforcement, interpretation or application, or the effect they will have on our business operations or operating results, which could be materially adverse. Even if we could predict such matters, it is not possible to eliminate the adverse impact of public policy changes that would fundamentally change the dynamics of one or more of the industries in which we compete. Examples of such changes include: the federal or one or more state governments fundamentally restructuring or reducing the funding available for Medicare, Medicaid, dual eligible or dual eligible special needs plan programs, increasing its involvement in drug reimbursement, pricing, purchasing and/or importation, changing the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, changing the tax treatment of health or related benefits, or repealing or otherwise significantly altering the ACA. The likelihood of adverse changes remains high due to state and federal budgetary pressures, and our businesses and operating results could be materially and adversely affected by such changes, even if we correctly predict their occurrence.

For more information on these matters, see "Government Regulation" included in Item 1 of this 10-K.

If we fail to comply with applicable laws and regulations, many of which are highly complex, we could be subject to significant adverse regulatory actions or suffer brand and reputational harm.

Our businesses are subject to extensive regulation and oversight by state, federal and international governmental authorities. The laws and regulations governing our operations and interpretations of those laws and regulations are increasing in number and complexity, change frequently and can be inconsistent or conflict with one another. In general, these laws and regulations are designed to benefit and protect customers, members and providers rather than us or our investors. In addition, the governmental authorities that regulate our businesses have broad latitude to make, interpret and enforce the laws and regulations that govern us and continue to interpret and enforce those laws and regulations more strictly and more aggressively each year. We also must follow various restrictions on certain of our businesses and the payment of dividends by certain of our subsidiaries put in place by certain state regulators.

Certain of our Pharmacy Services and Retail/LTC operations, products and services are subject to:

- the clinical quality, patient safety and other risks inherent in the dispensing, packaging and distribution of drugs and other health care products and services, including claims related to purported dispensing and other operational errors (any failure by our Pharmacy Services and/or Retail/LTC operations to adhere to the laws and regulations applicable to the dispensing of drugs could subject us to civil and criminal penalties);
- federal and state anti-kickback and other laws that govern our relationship with drug manufacturers, customers and consumers;
- compliance requirements under ERISA, including fiduciary obligations in connection with the development and implementation of items such as drug formularies and preferred drug listings; and
- federal and state legislative proposals and/or regulatory activity that could adversely affect pharmacy benefit industry practices.

Our Health Care Benefits products are highly regulated, particularly those that serve Medicare, Medicaid, dual eligible, dual eligible special needs and small group Commercial customers and members. The laws and regulations governing participation in Medicare Advantage, Medicare Part D, Medicaid, dual eligible and dual eligible special needs plan programs are complex, are subject to interpretation and can expose us to penalties for non-compliance.

The scope of the practices and activities that are prohibited by federal and state false claims acts is the subject of pending litigation. Claims under federal and state false claims acts can be brought by the government or by private individuals on behalf of the government through a *qui tam* or "whistleblower" suit, and we are a defendant in a number of such proceedings. If we are convicted of fraud or other criminal conduct in the performance of a government program or if there is an adverse decision against us under the False Claims Act, we may be temporarily

or permanently suspended from participating in government health care programs, including Medicare Advantage, Medicare Part D, Medicaid, dual eligible and dual eligible special needs plan programs, and we also may be required to pay significant fines and/or other monetary penalties. Whistleblower suits have

resulted in significant settlements between governmental agencies and health care companies. The significant incentives and protections provided to whistleblowers under applicable law increase the risk of whistleblower suits.

If we fail to comply with laws and regulations that apply to government programs, we could be subject to criminal fines, civil penalties, premium refunds, prohibitions on marketing or active or passive enrollment of members, corrective actions, termination of our contracts or other sanctions which could have a material adverse effect on our ability to participate in Medicare Advantage, Medicare Part D, Medicaid, dual eligible, dual eligible special needs plan and other programs and on our operating results, cash flows and financial condition.

Our businesses, profitability and growth also may be adversely affected by (i) judicial and regulatory decisions that change and/or expand the interpretations of existing statutes and regulations, impose medical or bad faith liability, increase our responsibilities under ERISA or the remedies available under ERISA, or reduce the scope of ERISA pre-emption of state law claims or (ii) other legislation and regulations. For example, in December 2020, the U.S. Supreme Court upheld an Arkansas law that, among other things, mandates a particular pricing methodology, establishes an appeals process for a pharmacy when the reimbursement is below the pharmacy's acquisition cost, permits a pharmacy to reverse and rebill if they cannot procure the drug from its wholesaler at a price equal to or less than the reimbursement rate, prohibits a PBM from reimbursing a pharmacy less than the amount it reimburses an affiliate on a per unit basis, and permits a pharmacy to decline to dispense if the reimbursement is lower than the pharmacy's acquisition cost.

If our compliance or other systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions and/or litigation.

In addition to being subject to extensive and complex regulations, many of our contracts with customers include detailed requirements. In order to be eligible to offer certain products or bid on certain contracts, we must demonstrate that we have robust systems and processes in place that are designed to maintain compliance with all applicable legal, regulatory and contractual requirements. These systems and processes frequently are reviewed and audited by our customers and regulators. If our systems and processes designed to maintain compliance with applicable legal and contractual requirements, and to prevent and detect instances of, or the potential for, non-compliance fail or are deemed inadequate, we may suffer brand and reputational harm and be subject to regulatory actions, litigation and other proceedings which may result in damages, fines, suspension or loss of licensure, suspension or exclusion from participation in government programs and/or other penalties, any of which could adversely affect our businesses, operating results, cash flows and/or financial condition.

We routinely are subject to litigation and other adverse legal proceedings, including class actions and qui tam actions. Many of these proceedings seek substantial damages which may not be covered by insurance. These proceedings are costly to defend, may result in changes in our business practices, harm our brand and reputation and adversely affect our businesses and operating results.

PBM, retail pharmacy, mail order pharmacy, specialty pharmacy, LTC pharmacy and health care and related benefits are highly regulated industries whose participants frequently are subject to litigation and other adverse legal proceedings. We are currently subject to various litigation and arbitration matters, investigations, regulatory audits, inspections, government inquiries, and regulatory and other legal proceedings, both inside and outside the U.S. Outside the U.S., contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the U.S. Litigation related to our provision of professional services in our medical clinics, pharmacies and LTC operations is increasing as we expand our services along the continuum of health care.

Litigation, and particularly securities, derivative, collective or class action and *qui tam* litigation, is often expensive and disruptive. Many of the legal proceedings against us seek substantial damages (including non-economic or punitive damages and treble damages), and certain of these proceedings also seek changes in our business practices. While we currently have insurance coverage for some potential liabilities, other potential liabilities may not be covered by insurance, insurers may dispute coverage and/or the amount of our insurance may not be enough to cover the damages awarded or costs incurred. In addition, some types of damages, like punitive damages, may not be covered by insurance, and in some jurisdictions the coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability also may become unavailable or prohibitively expensive in the future.

The outcome of litigation and other adverse legal proceedings is always uncertain, and outcomes that are not justifiable by the evidence or existing law or regulation can and do occur, and the costs incurred frequently are substantial regardless of the outcome. Litigation and other adverse legal proceedings could materially adversely affect our businesses, operating results and/or cash flows because of brand and reputational harm to us caused by such proceedings, the cost of defending such proceedings,

the cost of settlement or judgments against us, or the changes in our operations that could result from such proceedings. See Item 3 of this 10-K for additional information.

We frequently are subject to regular and special governmental audits, investigations and reviews that could result in changes to our business practices and also could result in material refunds, fines, penalties, civil liabilities, criminal liabilities and other sanctions.

As one of the largest national retail, mail order, specialty and LTC pharmacy, PBM and health care and related benefits providers, we frequently are subject to regular and special governmental market conduct and other audits, investigations and reviews by, and we receive subpoenas and other requests for information from, various federal and state agencies, regulatory authorities, attorneys general, committees, subcommittees and members of the U.S. Congress and other state, federal and international governmental authorities. For example, we have received CIDs from, and provided documents and information to, the Civil Division of the DOJ in connection with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. CMS and the OIG also are auditing the risk adjustment-related data of certain of our Medicare Advantage plans, and the number of such audits continues to increase. Several such audits, investigations and reviews by governmental authorities currently are pending, some of which may be resolved in 2021, the results of which may be adverse to us.

Federal and state governments have made investigating and prosecuting health care and other insurance fraud, waste and abuse a priority. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical and/or other covered services, improper marketing and violations of patient privacy rights. The regulations and contractual requirements applicable to us and other industry participants are complex and subject to change, making it necessary for us to invest significant resources in complying with our regulatory and contractual requirements. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources. In addition, our medical costs and the medical expenses of our Health Care Benefits ASC customers may be adversely affected if we do not prevent or detect fraudulent activity by providers and/or members.

Regular and special governmental audits, investigations and reviews by federal, state and international regulators could result in changes to our business practices, and also could result in significant or material premium refunds, fines, penalties, civil liabilities, criminal liabilities or other sanctions, including suspension or exclusion from participation in government programs and suspension or loss of licensure. Any of these audits, investigations or reviews could have a material adverse effect on our businesses, operating results, cash flows and/or financial condition or result in significant liabilities and negative publicity for us.

See “Legal and Regulatory Proceedings” in Note 16 ‘‘Commitments and Contingencies’’ included in Item 8 of this 10-K for additional information.

Our litigation and regulatory risk profile are changing as we offer new products and services and expand in business areas beyond our historical core businesses of Pharmacy Services, Retail/LTC and Health Care Benefits.

Historically, we focused primarily on providing Pharmacy Services, Retail/LTC and Health Care Benefits products and services. As a result of our transformation program and other innovation initiatives, we are expanding our presence in the health care space and plan to offer new products and services (such as the home hemodialysis device we are developing) which present a different litigation and regulatory risk profile than the products and services that we historically have offered.

The increased volume of business in areas beyond our historical core businesses and new products and services subject us to litigation and regulatory risks that are different from the risks of providing Pharmacy Services, Retail/LTC and Health Care Benefits products and services and increase significantly our exposure to other risks.

We face unique regulatory and other challenges in our Medicare and Medicaid businesses.

We are seeking to substantially grow the Medicare and Medicaid membership in our Health Care Benefits segment in 2020 and over the next several years. We face unique regulatory and other challenges that may inhibit the growth and profitability of those businesses.

- In April 2020, CMS issued a final notice detailing final Medicare Advantage benchmark payment rates for 2021 (the "Final Notice"). Overall, we project the benchmark rates in the Final Notice will increase funding for our Medicare Advantage

business, excluding the impact of the HIF in 2020, by approximately 1.8% in 2021 compared to 2020. This 2021 rate increase only partially offsets the challenge we face from the impact of the increasing cost of medical care (including prescription medications) and CMS local and national coverage decisions that require us to pay for services and supplies that are not factored into our bids and creates continued pressure on our Medicare Advantage operating results. In January 2021, CMS issued its final notice detailing final 2022 Medicare Advantage benchmark payment rates. Final 2022 Medicare Advantage rates resulted in an increase in industry benchmark rates of approximately 4.1%. We cannot predict future Medicare funding levels, the impact of future federal budget actions or ensure that such changes or actions will not have an adverse effect on our Medicare operating results.

- The organic expansion of our Medicare Advantage and Medicare Part D service area is subject to the ability of CMS to process our requests for service area expansions and our ability to build cost competitive provider networks in the expanded service areas that meet applicable network adequacy requirements. CMS' decisions on our requests for service area expansions also may be affected adversely by compliance issues that arise each year in our Medicare operations.
- CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of the services we provide to our Medicare members. As a result of these audits, we may be subject to significant or material retroactive adjustments to and/or withholding of certain premiums and fees, fines, criminal liability, civil monetary penalties, CMS imposed sanctions (including suspension or exclusion from participation in government programs) or other restrictions on our Medicare, Medicaid and other businesses, including suspension or loss of licensure.
- "Star ratings" from CMS for our Medicare Advantage plans will continue to have a significant effect on our plans' operating results. Since 2015, only Medicare Advantage plans with a star rating of four or higher (out of five) are eligible for a quality bonus in their basic premium rates. CMS continues to change its rating system to make achieving and maintaining a four or higher star rating more difficult. Our star ratings and past performance scores are adversely affected by the compliance issues that arise each year in our Medicare operations. If our star ratings fall below four for a significant portion of our Medicare Advantage membership or do not match the performance of our competitors or the star rating quality bonuses are reduced or eliminated, our revenues, operating results and cash flows may be significantly adversely affected.
- Payments we receive from CMS for our Medicare Advantage and Part D businesses also are subject to risk adjustment based on the health status of the individuals we enroll. Elements of that risk adjustment mechanism continue to be challenged by the DOJ, the OIG and CMS itself. Substantial changes in the risk adjustment mechanism, including changes that result from enforcement or audit actions, could materially affect the amount of our Medicare reimbursement, require us to raise prices or reduce the benefits we offer to Medicare beneficiaries, and potentially limit our (and the industry's) participation in the Medicare program.
- Changes to the ability of PBMs to have pharmacy performance programs in place for clients and report payments via direct and indirect reporting mechanisms could impact the Pharmacy Services business.
- Medicare Part D has resulted in increased utilization of prescription medications and puts pressure on our pharmacy gross margin rates due to regulatory and competitive pressures. Further, as a result of the ACA and changes to the retiree drug subsidy rules, clients of our PBM business could decide to discontinue providing prescription drug benefits to their Medicare-eligible members. To the extent this phenomenon occurs, the adverse effects of increasing customer migration into Medicare Part D may outweigh the benefits we realize from growth of our Medicare Part D products.
- Our Medicare Part D operating results and our ability to expand our Medicare Part D business could be adversely affected if: the cost and complexity of Medicare Part D exceed management's expectations or prevent effective program implementation or administration; changes to the regulations regarding how drug costs are reported for Medicare Part D are implemented in a manner that adversely affects the profitability of our Medicare Part D business; changes to the applicable regulations impact our ability to retain fees from third parties including network pharmacies; the government alters Medicare Part D program requirements or reduces funding because of the higher-than-anticipated cost to taxpayers of Medicare Part D or for other reasons; the government mandated use of point-of-sale manufacturer's rebates effective in 2022 continues; the government makes changes to how pharmacy pay-for-performance is calculated; or reinsurance thresholds are reduced below their current levels.
- We have experienced challenges in obtaining complete and accurate encounter data for our Medicaid products due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data,

these difficulties could affect the Medicaid premium rates we receive and how Medicaid membership is assigned to us, which could have a material adverse effect on our Medicaid operating results and cash flows and/or our ability to bid for, and continue to participate in, certain Medicaid programs.

- Federal funding for expanded Medicaid coverage began to decrease in 2017. This reduction is causing states to re-evaluate funding for their Medicaid expansions. That re-evaluation may adversely affect Medicaid payment rates, our Medicaid membership in those states, our revenues, our MLRs and our operating results.
- If we fail to report and correct errors discovered through our own auditing procedures or during a CMS audit or otherwise fail to comply with the applicable laws and regulations, we could be subject to fines, civil monetary penalties or other sanctions, including fines and penalties under the False Claims Act, which could have a material adverse effect on our ability to participate in Medicare Advantage, Part D or other government programs, and on our operating results, cash flows and financial condition.
- In the second quarter of 2014, CMS issued a final rule implementing ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. However, CMS's statements in formalized guidance regarding "overpayments" to Medicare Advantage plans appear to be inconsistent with CMS's prior RADV audit guidance. These statements appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without reconciliation to the principles underlying the fee for service adjustment comparison contemplated by CMS's RADV audit methodology. The precise interpretation, impact and legality of the final rule are not clear and are subject to pending litigation. If Medicare Advantage plans were not paid based on payment model principles that align with the requirements of the Social Security Act or such payments were not implemented correctly, it could have a material adverse effect on our operating results, cash flows and/or financial condition.
- Certain of our Medicaid contracts require the submission of complete and correct encounter data. The accurate and timely reporting of encounter data is increasingly important to the success of our Medicaid programs because more states are using encounter data to determine compliance with performance standards and, in part, to set premium rates. We have expended and may continue to expend additional effort and incur significant additional costs to collect accurate, or to correct inaccurate or incomplete, encounter data and have been and could be exposed to premium withholding, operating sanctions and financial fines and penalties for noncompliance. We have experienced challenges in obtaining complete and accurate encounter data due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could affect the Medicaid premium rates we receive and how Medicaid membership is assigned to us, which could have a material adverse effect on our Medicaid operating results and cash flows and/or our ability to bid for, and continue to participate in, certain Medicaid programs.
- Our businesses that dispense drugs also face challenges in the Medicaid space. The ACA made several significant changes to Medicaid rebates and to reimbursement rates. One of these changes was to revise the definition of the Average Manufacturer Price, a pricing element common to most payment formulas, and the reimbursement formula for generic drugs. This change has adversely affected the reimbursements we receive when we dispense prescription drugs to Medicaid recipients.

Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues, and we expect that percentage to increase.

Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues, and we expect that percentage to increase. As our government funded businesses grow, our exposure to changes in federal and state government policy with respect to and/or regulation of the various government funded programs in which we participate also increases.

Our revenues from government funded programs, including in Health Care Benefits' Medicare, Medicaid, dual eligible and dual eligible special needs plan businesses and from government customers in its Commercial business, are dependent on annual funding by the federal government and/or applicable state or local governments. Federal, state and local governments have the right to cancel or not to renew their contracts with us on short notice without cause or if funds are not available. Funding for these programs is dependent on many factors outside our control, including general economic conditions, continuing government efforts to contain health care costs and budgetary constraints at the federal or applicable state or local level and general political issues and priorities.

The U.S. federal government and our other government customers also may reduce funding for health care or other programs, cancel or decline to renew contracts with us, or make changes that adversely affect the number of persons eligible for certain programs, the services provided to enrollees in such programs, our premiums and our administrative and health care and other benefit costs, any of which could have a material adverse effect on our

businesses, operating results and cash flows. When federal funding is delayed, suspended or curtailed, we continue to receive, and we remain liable for and are required to fund, claims from providers for providing services to beneficiaries of federally funded health benefits programs in which we participate. An extended federal government shutdown or a delay by Congress in raising the federal government's debt ceiling

also could lead to a delay, reduction, suspension or cancellation of federal government spending and a significant increase in interest rates that could, in turn, have a material adverse effect on the value of our investment portfolio, our ability to access the capital markets and our businesses, operating results, cash flows and liquidity.

Possible changes in industry pricing benchmarks and drug pricing generally can adversely affect our PBM and Retail/LTC businesses.

It is possible that the pharmaceutical industry or regulators may evaluate and/or develop an alternative pricing reference to replace AWP or Wholesale Acquisition Cost ("WAC"), which are the pricing references used for many of our PBM and LTC client contracts, drug purchase agreements, retail network contracts, specialty payor agreements and other contracts with third party payors in connection with the reimbursement of drug payments. In addition, many state Medicaid fee-for-service programs have established pharmacy network payments on the basis of Actual Acquisition Cost ("AAC"). The use of an AAC basis in FFS Medicaid could have an impact on reimbursement practices in Health Care Benefits' Commercial and other Government products.

Future changes to the use of AWP, WAC or to other published pricing benchmarks used to establish drug pricing, including changes in the basis for calculating reimbursement by federal and state health care programs and/or other payors, could impact the reimbursement we receive from Medicare and Medicaid programs, the reimbursement we receive from our PBM clients and other payors and/or our ability to negotiate rebates and/or discounts with drug manufacturers, wholesalers, PBMs and retail pharmacies. A failure or inability to fully offset any increased prices or costs or to modify our operations to mitigate the impact of such increases could have a material adverse effect on our operating results. Additionally, any future changes in drug prices could be significantly different than our projections. We cannot predict the effect of these possible changes on our businesses.

We may not be able to obtain adequate premium rate increases in our Insured Health Care Benefits products, which would have an adverse effect on our revenues, MBRs and operating results and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes.

Premium rates for our Insured Health Care Benefits products generally must be filed with state insurance regulators and are subject to their approval, which creates risk for us in the current political and regulatory environment. The ACA generally requires a review by HHS in conjunction with state regulators of premium rate increases that exceed a federally specified threshold (or lower state-specific thresholds set by states determined by HHS to have adequate processes). Rate reviews can magnify the adverse impact on our operating margins, MBRs and operating results of increases in health care and other benefit costs, increased utilization of covered services, and ACA assessments, fees and taxes, by restricting our ability to reflect these increases and/or these assessments, fees and taxes in our pricing. Further, our ability to reflect ACA assessments, fees and taxes in our Medicare, Medicaid and CHIP premium rates is limited.

Since 2013, HHS has issued determinations to health plans that their premium rate increases were "unreasonable," and we continue to experience challenges to appropriate premium rate increases in certain states. Regulators or legislatures in several states have implemented or are considering limits on premium rate increases, either by enforcing existing legal requirements more stringently or proposing different regulatory standards. Regulators or legislatures in several states also have conducted hearings on proposed premium rate increases, which can result, and in some instances have resulted, in substantial delays in implementing proposed rate increases even if they ultimately are approved. Our plans can be excluded from participating in small group Public Exchanges if they are deemed to have a history of "unreasonable" rate increases. Any significant rate increases we may request heighten the risks of adverse publicity, adverse regulatory action and adverse selection and the likelihood that our requested premium rate increases will be denied, reduced or delayed, which could adversely affect our MBRs and lead to operating margin compression.

We anticipate continued regulatory and legislative action to increase regulation of premium rates in our Insured Health Care Benefits products. We may not be able to obtain rates that are actuarially justified or that are sufficient to make our policies profitable in one or more product lines or geographies. If we are unable to obtain adequate premium rates and/or premium rate increases, it could materially and adversely affect our operating margins and MBRs and our ability to earn adequate returns on Insured Health Care Benefits products in one or more states or cause us to withdraw from certain geographies and/or products.

Minimum MLR rebate requirements limit the level of margin we can earn in our Insured Health Care Benefits products while leaving us exposed to higher than expected medical costs. Challenges to our minimum MLR rebate methodology and/or reports could adversely affect our operating results.

The ACA's minimum MLR rebate requirements limit the level of margin we can earn in Health Care Benefits' Commercial Insured and Medicare Insured businesses. CMS minimum MLR rebate regulations limit the level of margin we can earn in our Medicaid Insured business. Certain portions of our Health Care Benefits Medicaid and Federal Employees Health Benefits ("FEHB") program business also are subject to minimum MLR rebate requirements in addition to but separate from those imposed by the ACA. Minimum MLR rebate requirements leave us exposed to medical costs that are higher than those reflected in our pricing. The process supporting the management and determination of the amount of MLR rebates payable is complex and requires judgment, and the minimum MLR reporting requirements are detailed. CMS has also proposed, but not yet finalized, a definition of "prescription drug price concessions" for commercial MLR calculation purposes, which would make additional PBM information available to plans and the HHS, potentially further complicating the MLR calculation process. Federal and state auditors are challenging our Commercial Health Care Benefits business' compliance with the ACA's minimum MLR requirements as well as our FEHB plans' compliance with OPM's FEHB program-specific minimum MLR requirements. Our Medicare and Medicaid contracts also are subject to minimum MLR audits. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS. Additional challenges to our methodology and/or reports relating to minimum MLR and related rebates by federal and state regulators and private litigants are reasonably possible. The outcome of these audits and additional challenges could adversely affect our operating results.

Our operating results may be adversely affected by changes in laws and policies governing employers and by union organizing activity.

The federal and certain state legislatures continue to consider and pass legislation that increases our costs of doing business, including increased minimum wages and requiring employers to provide paid sick leave or paid family leave. In addition, our employee-related operating costs may be increased by union organizing activity. If we are unable to reflect these increased expenses in our pricing or otherwise modify our operations to mitigate the effects of such increases, our operating results will be adversely affected.

We face international political, legal and compliance, operational, regulatory, economic and other risks that may be more significant than in our domestic operations.

We significantly expanded our international operations as a result of the Aetna Acquisition. As a result of our expanded international operations, we face political, legal, compliance, operational, regulatory, economic and other risks that we do not face or that are more significant than in our domestic operations. These risks vary widely by country and include varying regional and geopolitical business conditions and demands, government intervention and censorship, discriminatory regulation, nationalization or expropriation of assets and pricing constraints. Our international products need to meet country-specific customer and member preferences as well as country-specific legal requirements, including those related to licensing, data privacy, data storage and data protection.

Our international operations increase our exposure to, and require us to devote significant management resources to implement controls and systems to comply with, the privacy and data protection laws of non-U.S. jurisdictions, such as the EU's GDPR, and the anti-bribery, anti-corruption and anti-money laundering laws of the United States (including the FCPA) and the United Kingdom (including the UK Bribery Act) and similar laws in other jurisdictions. Implementing our compliance policies, internal controls and other systems upon our expansion into new countries and geographies may require the investment of considerable management time and financial and other resources over several years before any significant revenues or profits are generated. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or employees, restrictions or outright prohibitions on the conduct of our business, and significant brand and reputational harm. We must regularly reassess the size, capability and location of our global infrastructure and make appropriate changes, and must have effective change management processes and internal controls in place to address changes in our businesses and operations. Our success depends, in part, on our ability to anticipate these risks and manage these difficulties, and the failure to do so could have a material adverse effect on our brand, reputation, businesses, operating results and/or financial condition.

Our international operations require us to overcome logistical and other challenges based on differing languages, cultures, legal and regulatory schemes and time zones. Our international operations encounter labor laws, standards and customs that can be difficult and make employee relationships less flexible than in our domestic operations and expensive to modify or terminate. In

some countries we are required to, or choose to, operate with local business associates, which requires us to manage our relationships with these third parties and may reduce our operational flexibility and ability to quickly respond to business challenges.

In some countries we may be exposed to currency exchange controls or other restrictions that prevent us from transferring funds internationally or converting local currencies into U.S. dollars or other currencies. Fluctuations in foreign currency exchange rates may adversely affect our revenues, operating results and cash flows from our international operations. Some of our operations are, and are increasingly likely to be, in emerging markets where these risks are heightened. Any measures we may implement to reduce the effect of volatile currencies and other risks on our international operations may not be effective.

Risks Associated with Mergers, Acquisitions, and Divestitures

We may be unable to successfully integrate companies we acquire.

Upon the closing of any acquisition we complete, we will need to successfully integrate the products, services and related assets, as well as internal controls into our business operations. If an acquisition is consummated, the integration of the acquired business, its products, services and related assets into our company also may be complex and time-consuming and, if the integration is not fully successful, we may not achieve the anticipated benefits, operating and cost synergies and/or growth opportunities of an acquisition. Potential difficulties that may be encountered in the integration process include the following:

- Integrating personnel, operations and systems (including internal control environments and compliance policies), while maintaining focus on producing and delivering consistent, high quality products and services;
- Coordinating geographically dispersed organizations;
- Disrupting management's attention from our ongoing business operations;
- Retaining existing customers and attracting new customers; and
- Managing inefficiencies associated with integrating our operations.

An inability to realize the full extent of the anticipated benefits, operating and cost synergies, innovations and operations efficiencies or growth opportunities of an acquisition, as well as any delays or additional expenses encountered in the integration process, could have a material adverse effect on our businesses and operating results. Furthermore, acquisitions, even if successfully integrated, may fail to further our business strategy as anticipated, expose us to increased competition or challenges with respect to our products, services or service areas, and expose us to additional liabilities associated with an acquired business including risks and liabilities associated with litigation involving the acquired business. Any one of these challenges or risks could impair our ability to realize any benefit from our acquisitions after we have expended resources on them.

We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities, which may be unsuccessful, cause us to assume unanticipated liabilities, disrupt our existing businesses, be dilutive or lead us to assume significant debt, among other things.

We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities as part of our growth strategy. In addition to the integration risks noted above, some other risks we face with respect to acquisitions and other inorganic growth strategies include:

- we frequently compete with other firms, some of which may have greater financial and other resources and a greater tolerance for risk, to acquire attractive companies;
- the acquired, alliance and/or joint venture businesses may not perform as projected;
- the goodwill or other intangible assets established as a result of our acquisitions may be incorrectly valued or may become impaired; for example, in 2018 we took $6.1 billion of goodwill impairment charges related to our LTC reporting unit within the Retail/LTC segment;
- we may assume unanticipated liabilities, including those that were not disclosed to us or which we underestimated;
- the acquired businesses, or the pursuit of other inorganic growth strategies, could disrupt or compete with our existing businesses, distract management, result in the loss of key employees, divert resources, result in tax costs

or inefficiencies and make it difficult to maintain our current business standards, controls, information technology systems, policies, procedures and performance;

- as we did in the Aetna Acquisition, we may finance future acquisitions and other inorganic growth strategies by issuing common stock for some or all of the purchase price, which would dilute the ownership interests of our stockholders;
- as we did in the Aetna Acquisition, we may incur significant debt in connection with acquisitions (whether to finance acquisitions or by assuming debt from the businesses we acquire);
- we may not have the expertise to manage and profitably grow the businesses we acquire, and we may need to rely on the retention of key personnel and other suppliers of businesses we acquire, which may be difficult or impossible to accomplish;
- we may enter into merger or purchase agreements but, due to reasons within or outside our control, fail to complete the related transactions, which could result in termination fees or other penalties that could be material, cause material disruptions to our businesses and operations and adversely affect our brand and reputation;
- in order to complete a proposed acquisition, we may be required to divest certain portions of our business, for which we may not be able to obtain favorable pricing;
- as is the case with the Aetna Acquisition and our acquisition of Omnicare, Inc., we may be involved in litigation related to mergers or acquisitions, including for matters that occurred prior to the applicable closing, which may be costly to defend and may result in adverse rulings against us that could be material; and
- the integration into our businesses of the businesses and entities we acquire may affect the way in which existing laws and regulations apply to us, including subjecting us to laws and regulations that did not previously apply to us.

In addition, joint ventures present risks that are different from acquisitions, including selection of appropriate joint venture parties, initial and ongoing governance of the joint venture, joint venture compliance activities (including compliance with applicable CMS requirements), growing the joint venture's business in a manner acceptable to all the parties, including other providers in the networks that include joint ventures, maintaining positive relationships among the joint venture parties and the joint venture's customers, and member and business disruption that may occur upon joint venture termination.

Risks Related to Our Operations

Failure to meet customer expectations may harm our brand and reputation, our ability to retain and grow our customer base and membership and our operating results and cash flows.

Our ability to attract and retain customers and members is dependent upon providing cost effective, quality customer service operations (such as call center operations, PBM functions, retail pharmacy and LTC services, retail, mail order and specialty pharmacy prescription delivery, claims processing, customer case installation and online access and tools) that meet or exceed our customers' and members' expectations, either directly or through vendors. As we seek to reduce general and administrative expenses, we must balance the potential impact of cost-saving measures on our customers and other services and performances. If we misjudge the effects of such measures, customers and other services may be adversely affected. We depend on third parties for certain of our customer service, PBM and prescription delivery operations. If we or our vendors fail to provide service that meets our customers' and members' expectations, we may have difficulty retaining or profitably growing our customer base and/or membership, which could adversely affect our operating results. For example, noncompliance with any privacy or security laws or regulations or any security breach involving us or one of our third-party vendors could have a material adverse effect on our businesses, operating results, brand and reputation.

We and our vendors have experienced and continue to experience cyber attacks. We can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future.

We and our vendors have experienced diverse cyber attacks and expect to continue to experience cyber attacks going forward. As examples, the Company and its vendors have experienced attempts to gain access to systems, denial of service attacks, attempted malware infections, account takeovers, scanning activity, and phishing emails. Attacks can originate from external criminals, terrorists, nation states, or internal actors. The Company is dedicating and will continue to dedicate significant resources and incur significant expenses to maintain and update on an ongoing basis the systems and processes that are designed to mitigate the information security risks it faces and protect the security

of its computer systems, software, networks and other technology assets against attempts by unauthorized parties to obtain access to confidential information, disrupt or degrade service, or cause other damage. The impact of cyber attacks has not been material to the Company's operations or operating results through December 31, 2020. The Board and its Audit Committee and Nominating and Corporate Governance Committee are regularly informed regarding the Company's information security policies, practices and status.

A compromise of our information security controls or of those businesses with whom we interact, which results in confidential information being accessed, obtained, damaged, or used by unauthorized or improper persons, could harm our reputation and expose us to regulatory actions and claims from customers and clients, financial institutions, payment card associations and other persons, any of which could adversely affect our businesses, operating results and financial condition. Because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may not immediately produce signs of intrusion, we may be unable to anticipate these techniques or to implement adequate preventative measures. Moreover, a data security breach could require that we expend significant resources related to our information systems and infrastructure, and could distract management and other key personnel from performing their primary operational duties. We also could be adversely affected by any significant disruption in the systems of third parties we interact with, including key payors and vendors.

The costs of attempting to protect against the foregoing risks and the costs of responding to a cyber-incident are significant. Large scale data breaches at other entities increase the challenge we and our vendors face in maintaining the security of our information technology systems and proprietary information and of our customers', members' and other constituents' sensitive information. Following a cyber-incident, our and/or our vendors' remediation efforts may not be successful, and a cyber-incident could result in interruptions, delays or cessation of service, and loss of existing or potential customers and members. In addition, breaches of our and/or our vendors' security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about us, our customers, our members or other third-parties, could expose our customers', members' and other constituents' private information and our customers, members and other constituents to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, and result in investigations, regulatory enforcement actions, material fines and penalties, loss of customers, litigation or other actions which could have a material adverse effect on our brand, reputation, businesses, operating results and cash flows.

Data governance failures can adversely affect our reputation, businesses and prospects. Our use and disclosure of members', customers' and other constituents' sensitive information is subject to complex regulations at multiple levels. We would be adversely affected if we or our business associates or other vendors fail to adequately protect members', customers' or other constituents' sensitive information.

Our information systems are critical to the operation of our businesses. We collect, process, maintain, retain, evaluate, utilize and distribute large amounts of personal health and financial information and other confidential and sensitive data about our customers, members and other constituents in the ordinary course of our businesses. Some of our information systems rely upon third party systems, including cloud service providers, to accomplish these tasks. The use and disclosure of such information is regulated at the federal, state and international levels, and these laws, rules and regulations are subject to change and increased enforcement activity, such as the California Consumer Privacy Act which went into effect January 1, 2020, the EU's GDPR which began to apply across the EU during 2018 and the audit program implemented by HHS under HIPAA. In some cases, such laws, rules and regulations also apply to our vendors and/or may hold us liable for any violations by our vendors. International laws, rules and regulations governing the use and disclosure of such information are generally more stringent than U.S. laws and regulations, and they vary from jurisdiction to jurisdiction. Noncompliance with any privacy or security laws or regulations, or any security breach, cyber attack or cybersecurity breach, and any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, sensitive or confidential customer, member or other constituent information, whether by us, by one of our business associates or vendors or by another third party, could require us to expend significant resources to remediate any damage, could interrupt our operations and could adversely affect our brand and reputation, membership and operating results and also could expose and/or has exposed us to mandatory disclosure to the media, litigation (including class action litigation), governmental investigations and enforcement proceedings, material fines, penalties and/or remediation costs, and compensatory, special, punitive and statutory damages, consent orders, adverse actions against our licenses to do business and/or injunctive relief, any of which could adversely affect our businesses, operating results, cash flows or financial condition.

Our businesses depend on our customers', members' and other constituents' willingness to entrust us with their health related and other sensitive personal information. Events that adversely affect that trust, including inadequate disclosure to our members or customers of our uses of their information, failing to keep our information technology systems and our customers', members' and other constituents' sensitive information secure from significant attack,

theft, damage, loss or unauthorized disclosure or access, whether as a result of our action or inaction (including human error) or that of our business associates, vendors or other third parties, could adversely affect our brand and reputation, membership and operating results and also could expose and/or has exposed us to mandatory disclosure to the media, litigation (including class action litigation), governmental investigations and enforcement proceedings, material fines, penalties and/or remediation costs, and compensatory, special, punitive and statutory damages, consent orders, adverse actions against our licenses to do business and/or injunctive relief, any of which

could adversely affect our businesses, operating results, cash flows or financial condition. Large scale data breaches at other entities increase the challenge we and our vendors face in maintaining the security of our information technology systems and proprietary information and of our customers', members' and other constituents' sensitive information. There can be no assurance that additional such failures will not occur, or if any do occur, that we will detect them or that they can be sufficiently remediated.

Product liability, product recall or personal injury issues could damage our reputation and have a significant adverse effect on our businesses, operating results, cash flows and/or financial condition.

The products that we sell could become subject to contamination, product tampering, mislabeling, recall or other damage. In addition, errors in the dispensing and packaging of drugs and consuming drugs in a manner that is not prescribed could lead to serious injury or death. Product liability or personal injury claims may be asserted against us with respect to any of the drugs or other products we sell or services we provide. For example, we are a defendant in hundreds of litigation proceedings relating to opioids and the sale of products containing talc. Our businesses involve the provision of professional services, including by pharmacists, physician assistants, nurses and nurse practitioners, which exposes us to professional liability claims. Should a product or other liability issue arise, the coverage available under our insurance programs and the indemnification amounts available to us from third parties may not be adequate to protect us against the financial impact of the related claims. We also may not be able to maintain our existing levels of insurance on acceptable terms in the future. A product liability or personal injury issue or judgment against us or a product recall could damage our reputation and have a significant adverse effect on our businesses, operating results and/or financial condition.

We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success, and our failure to do so could adversely affect our businesses, operating results and/or future performance.

Our ability to attract and retain qualified and experienced employees is essential to meet our current and future goals and objectives. There is no guarantee we will be able to attract and retain such employees or that competition among potential employers will not result in increased compensation and/or benefits costs. If we are unable to retain existing employees or attract additional employees, or we experience an unexpected loss of leadership, we could experience a material adverse effect on our businesses, operating results and/or future performance.

In addition, our failure to adequately plan for succession of senior management and other key management roles or the failure of key employees to successfully transition into new roles could have a material adverse effect on our businesses, operating results and/or future performance. The succession plans we have in place and our employment arrangements with certain key executives do not guarantee the services of these executives will continue to be available to us.

Sales of our products and services are dependent on our ability to attract and motivate internal sales personnel and independent third-party brokers, consultants and agents. New distribution channels create new disintermediation risk. We may be subject to penalties or other regulatory actions as a result of the marketing practices of brokers and agents selling our products.

Our products are sold primarily through our sales personnel, who frequently work with independent brokers, consultants and agents who assist in the production and servicing of business. The independent brokers, consultants and agents generally are not dedicated to us exclusively and may frequently recommend and/or market health care benefits products of our competitors. Accordingly, we must compete intensely for their services and allegiance. Our sales could be adversely affected if we are unable to attract, retain or motivate sales personnel and third-party brokers, consultants and agents, or if we do not adequately provide support, training and education to this sales network regarding our complex product portfolio, or if our sales strategy is not appropriately aligned across distribution channels. This risk is heightened as we develop, operate and expand our consumer-oriented products and services and we expand in the health care space and our business model evolves to include a greater focus on consumers and direct-to-consumer sales, such as competing for sales on Insurance Exchanges.

New distribution channels for our products and services continue to emerge, including Private Exchanges operated by health care consultants and technology companies. These channels may make it more difficult for us to directly engage consumers and other customers in the selection and management of their health care benefits, in health care

utilization and in the effective navigation of the health care system. We also may be challenged by new technologies and marketplace entrants that could interfere with our existing relationships with customers and health plan members in these areas.

In addition, there have been several investigations regarding the marketing practices of brokers and agents selling health care and other insurance products and the payments they receive. These investigations have resulted in enforcement actions against companies in our industry and brokers and agents marketing and selling those companies' products. For example, CMS and state departments of insurance have increased their scrutiny of the marketing practices of brokers and agents who market Medicare products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans and/or changes to industry practices, which could adversely affect our ability to market our products.

Failure of our businesses to effectively collaborate could prevent us from maximizing our operating results.

To maximize our overall enterprise value, our various businesses need to collaborate effectively. Our businesses need to be aligned in order to prioritize goals and coordinate the design of new products intended to utilize the offerings of multiple businesses, including our transformation and enterprise modernization programs. In addition, misaligned incentives, information siloes, ineffective product development and failure of our corporate governance policies or procedures, for example significant financial decisions being made at an inappropriate level in our organization, also could prevent us from maximizing our operating results and/or achieving our financial and other projections.

The failure or disruption of our information technology systems or the failure of our information technology infrastructure to support our businesses could adversely affect our reputation, businesses, operating results and cash flows.

Our information systems are subject to damage or interruption from power outages, facility damage, computer and telecommunications failures, computer viruses, security breaches (including credit card or personally identifiable information breaches), cyber attacks, vandalism, catastrophic events and human error. If our information systems are damaged, fail to work properly or otherwise become unavailable, we may incur substantial costs to repair or replace them, and may experience reputational damage, loss of critical information, customer disruption and interruptions or delays in our ability to perform essential functions and implement new and innovative services. In addition, compliance with changes in U.S. and foreign laws and regulations, including privacy and information security laws and standards, may cause us to incur significant expense due to increased investment in technology and the development of new operational processes.

Our business success and operating results depend in part on effective information technology systems and on continuing to develop and implement improvements in technology. Pursuing multiple initiatives simultaneously could make this continued development and implementation significantly more challenging.

Many aspects of our operations are dependent on our information systems and the information collected, processed, stored, and handled by these systems. We rely heavily on our computer systems to manage our ordering, pricing, point-of-sale, pharmacy fulfillment, inventory replenishment, claims processing, customer loyalty and subscription programs, finance and other processes. Throughout our operations, we collect, process, maintain, retain, evaluate, utilize and distribute large amounts of confidential and sensitive data and information, including personally identifiable information and protected health information, that our customers, members and other constituents provide to purchase products or services, enroll in programs or services, register on our websites, interact with our personnel, or otherwise communicate with us. In addition, for these operations, we depend in part on the secure transmission of confidential information over public networks.

We have many different information and other technology systems supporting our businesses (including as a result of our acquisitions). Our businesses depend in large part on these systems to adequately price our products and services; accurately establish reserves, process claims and report operating results; and interact with providers, employer plan sponsors, customers, members, consumers and vendors in an efficient and uninterrupted fashion. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Certain of our technology systems (including software) are older, legacy systems that are less flexible, less efficient and require a significant ongoing commitment of capital and human resources to maintain, protect and enhance them and to integrate them with our other systems. We must re-engineer and reduce the number of these systems to meet changing consumer and vendor preferences and needs, improve our productivity and reduce our operating expenses. We also need to develop or acquire new technology systems, contract with new vendors or modify certain of our existing systems to support the consumer-oriented and transformation products and services we are developing, operating and expanding and/or to meet current and

developing industry and regulatory standards, including to keep pace with continuing changes in information processing technology and emerging cybersecurity risks and threats. If we fail to achieve these objectives, our ability to profitably grow our business and/or our operating results may be adversely affected.

In addition, information technology and other technology and process improvement projects, including our transformation and enterprise modernization programs, frequently are long-term in nature and may take longer to complete and cost more than we

expect and may not deliver the benefits we project once they are complete. If we do not effectively and efficiently secure, manage, integrate and enhance our technology portfolio (including vendor sourced systems), we could, among other things, have problems determining health care and other benefit cost estimates and/or establishing appropriate pricing, meeting the needs of customers, consumers, providers, members and vendors, developing and expanding our consumer-oriented products and services or keeping pace with industry and regulatory standards, and our operating results may be adversely affected.

We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.

We accept payments using a variety of methods, including cash, checks, credit cards, debit cards, gift cards, mobile payments and potentially other technologies in the future. Acceptance of these payment methods subjects us to rules, regulations, contractual obligations and compliance requirements, including payment network rules and operating guidelines, data security standards and certification requirements, and rules governing electronic funds transfers. These requirements may change in the future, which could make compliance more difficult or costly. For certain payment options, including credit and debit cards, we pay interchange and other fees, which could increase periodically thereby raising our operating costs. We rely on third parties to provide payment processing services, including the processing of credit cards, debit cards, and various other forms of electronic payment. If these vendors are unable to provide these services to us, or if their systems are compromised, our operations could be disrupted. The payment methods that we offer also expose us to potential fraud and theft by persons seeking to obtain unauthorized access to, or exploit any weaknesses in, the payment systems we use. If we fail to abide by applicable rules or requirements, or if data relating to our payment systems is compromised due to a breach or misuse, we may be responsible for any costs incurred by payment card issuing banks and other third parties or subject to fines and higher transaction fees. In addition, our reputation and ability to accept certain types of payments could each be harmed resulting in reduced sales and adverse effects on our operating results.

Both our and our vendors' operations are subject to a variety of business continuity hazards and risks, any of which could interrupt our operations or otherwise adversely affect our performance and operating results.

We and our vendors are subject to business continuity hazards and other risks, including natural disasters, utility and other mechanical failures, acts of war or terrorism, acts of civil unrest, disruption of communications, data security and preservation, disruption of supply or distribution, safety regulation and labor difficulties. The occurrence of any of these or other events to us or our vendors might disrupt or shut down our operations or otherwise adversely affect our operations. We also may be subject to certain liability claims in the event of an injury or loss of life, or damage to property, resulting from such events. Although we have developed procedures for crisis management and disaster recovery and business continuity plans and maintain insurance policies that we believe are customary and adequate for our size and industry, our insurance policies include limits and exclusions and, as a result, our coverage may be insufficient to protect against all potential hazards and risks incident to our businesses. In addition, our crisis management and disaster recovery procedures and business continuity plans may not be effective. Should any such hazards or risks occur, or should our insurance coverage be inadequate or unavailable, our businesses, operating results, cash flows and financial condition could be adversely affected.

Financial Risks

We would be adversely affected if we do not effectively deploy our capital. Downgrades or potential downgrades in our credit ratings, should they occur, could adversely affect our brand and reputation, businesses, operating results, cash flows and financial condition.

Our operations generate significant capital, and we have the ability to raise additional capital. The manner in which we deploy our capital, including investments in our businesses, our operations (such as information technology and other strategic and capital projects), dividends, acquisitions, share and/or debt repurchases, repayment of debt, reinsurance or other capital uses, impacts our financial strength, claims paying ability and credit ratings issued by nationally-recognized statistical rating organizations. Credit ratings issued by nationally-recognized statistical rating organizations are broadly distributed and generally used throughout our industries. Our ratings reflect each rating organization's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to our insureds. We believe our credit ratings and the financial strength and claims paying ability of our

principal insurance and HMO subsidiaries are important factors in marketing our Health Care Benefits products to certain of our customers.

Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future. In connection with the completion of the Aetna Acquisition, each of Standard & Poor's, Moody's and

Fitch downgraded certain of our debt, financial strength and/or other credit ratings. Downgrades in our ratings could adversely affect our businesses, operating results, cash flows and financial condition.

Goodwill and other intangible assets could, in the future, become impaired.

As of December 31, 2020 and December 31, 2019, we had $110.7 billion and $112.9 billion, respectively, of goodwill and other intangible assets. Goodwill and indefinitely-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable. When evaluating goodwill for potential impairment, we compare the fair value of our reporting units to their respective carrying amounts. We estimate the fair value of our reporting units using a combination of a discounted cash flow method and a market multiple method. If the carrying amount of a reporting unit exceeds its estimated fair value, a goodwill impairment loss is recognized in an amount equal to the excess to the extent of the goodwill balance. Estimated fair values could change if, for example, there are changes in the business climate, industry-wide changes, changes in the competitive environment, adverse legal or regulatory actions or developments, changes in capital structure, cost of debt, interest rates, capital expenditure levels, operating cash flows or market capitalization. Because of the significance of our goodwill and intangible assets, any future impairment of these assets could require material noncash charges to our operating results, which also could have a material adverse effect on our financial condition.

Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative investments and other investments, and our operating results and/or our financial condition.

The global capital markets, including credit markets, continue to experience volatility and uncertainty. As an insurer, we have a substantial investment portfolio that supports our policy liabilities and surplus and is comprised largely of debt securities of issuers located in the U.S. As a result, the income we earn from our investment portfolio is largely driven by the level of interest rates in the U.S., and to a lesser extent the international financial markets; and volatility, uncertainty and/or disruptions in the global capital markets, particularly the U.S. credit markets, and governments' monetary policy, particularly U.S. monetary policy, can significantly and adversely affect the value of our investment portfolio, our operating results and/or our financial condition by:

- significantly reducing the value and/or liquidity of the debt securities we hold in our investment portfolio and creating realized capital losses that reduce our operating results and/or unrealized capital losses that reduce our shareholders' equity;
- keeping interest rates low on high-quality short-term or medium-term debt securities (such as we have experienced during recent years) and thereby materially reducing our net investment income and operating results as the proceeds from securities in our investment portfolio that mature or are otherwise disposed of continue to be reinvested in lower yielding securities;
- reducing the fair values of our investments if interest rates rise;
- causing non-performance of or defaults on their obligations to us by third parties, including customers, issuers of securities in our investment portfolio, mortgage borrowers and/or reinsurance and/or derivatives counterparties;
- making it more difficult to value certain of our investment securities, for example if trading becomes less frequent, which could lead to significant period-to-period changes in our estimates of the fair values of those securities and cause period-to-period volatility in our net income and shareholders' equity;
- reducing our ability to issue short-term debt securities at attractive interest rates, thereby increasing our interest expense and decreasing our operating results; and
- reducing our ability to issue other securities.

Although we seek, within guidelines we deem appropriate, to match the duration of our assets and liabilities and to manage our credit and counterparty exposures, a failure adequately to do so could adversely affect our net income and our financial condition and, in extreme circumstances, our cash flows.

We have incurred and assumed significant indebtedness which has increased our consolidated interest expense and could adversely affect our business flexibility and increase our borrowing costs.

In order to complete the Aetna Acquisition, we incurred acquisition-related debt financing of approximately $45.0 billion and assumed Aetna's existing indebtedness with a fair value of approximately $8.1 billion. Our substantial indebtedness and elevated debt-to-equity ratio have the effect, among other things, of reducing our flexibility to respond to changing business and economic conditions and increasing our interest expense compared to pre-Aetna Acquisition periods. In addition, the amount of

cash required to service our increased indebtedness levels and thus the demands on our cash resources are greater than the amount of cash flows required to service our indebtedness prior to the Aetna Acquisition. We have suspended share repurchases until we reach our desired debt-to-equity ratio. The increased levels of indebtedness also could reduce funds available to engage in investments in product development, capital expenditures, dividend payments and other activities and may create competitive disadvantages for us relative to other companies with lower debt levels.

Risks Related to Our Relationships with Manufacturers, Providers, Suppliers and Vendors

We face risks relating to the market availability, pricing, suppliers and safety profiles of prescription drugs and other products that we purchase and sell.

Our Retail/LTC segment and our mail order and specialty pharmacy operations generate revenues in significant part by dispensing prescription drugs. Our PBM business generates revenues primarily by contracting with clients to provide prescription drugs and related health care services to plan members. As a result, we are dependent on our relationships with prescription drug manufacturers and suppliers. We acquire a substantial amount of our mail order and specialty pharmacies' prescription drug supply from a limited number of suppliers. Certain of our agreements with such suppliers are short-term and cancelable by either party without cause. In addition, these agreements may allow the supplier to distribute through channels other than us. Certain of these agreements also allow pricing and other terms to be adjusted periodically for changing market conditions or required service levels. A termination or modification to any of these relationships could adversely affect our prescription drug supply and have a material adverse effect on our businesses, operating results and financial condition. Moreover, many products distributed by our pharmacies are manufactured with ingredients that are susceptible to supply shortages. In some cases, we depend upon a single source of supply. Any such supply shortages or loss of any such single source of supply could adversely affect our operating results and cash flows.

Much of the branded and generic drug product that we sell in our pharmacies, and much of the other merchandise we sell, is manufactured in whole or in substantial part outside of the United States. In most cases, the products or merchandise are imported by others and sold to us. As a result, significant changes in tax or trade policies, tariffs or trade relations between the United States and other countries, such as the imposition of unilateral tariffs on imported products, could result in significant increases in our costs, restrict our access to suppliers, depress economic activity, and have a material adverse effect on our businesses, operating results and cash flows. In addition, other countries may change their business and trade policies and such changes, as well as any negative sentiments towards the United States in response to increased import tariffs and other changes in U.S. trade regulations, could adversely affect our businesses.

Our suppliers are independent entities subject to their own operational and financial risks that are outside our control. If our current suppliers were to stop selling prescription drugs to us or delay delivery, including as a result of supply shortages, supplier production disruptions, supplier quality issues, closing or bankruptcies of our suppliers, or for other reasons, we may be unable to procure alternatives from other suppliers in a timely and efficient manner and on acceptable terms, or at all.

Our operating results may be adversely affected if we are unable to contract with providers on competitive terms and develop and maintain attractive networks with high quality providers.

We are seeking to enhance our health care provider networks by entering into joint ventures and other collaborative risk-sharing arrangements with providers. Providers' willingness to enter these arrangements with us depends upon, among other things, our ability to provide them with up to date quality of care data to support these value-based contracts. These arrangements are designed to give providers incentives to engage in population health management and optimize delivery of health care to our members. These arrangements also may allow us to expand into new geographies, target new customer groups, increase membership and reduce medical costs and, if we provide technology or other services to the relevant health system or provider organization, may contribute to our revenue and earnings from alternative sources. If such arrangements do not result in the lower medical costs that we project or if we fail to attract providers to such arrangements, or are less successful at implementing such arrangements than our competitors, our medical costs may not be competitive and may be higher than we project, our attractiveness to customers may be reduced, we may lose or be unable to grow medical membership, and our ability to profitably grow our business and/or our operating results may be adversely affected.

While we believe joint ventures, accountable care organizations ("ACOs") and other non-traditional health care provider organizational structures present opportunities for us, the implementation of our joint ventures and other non-traditional structure strategies may not achieve the intended results, which could adversely affect our operating results and cash flows. Among other things, joint ventures require us to maintain collaborative relationships with our counterparties, continue to gain access to provider rates that make the joint ventures economically sustainable and devote significant management time to the

operation and management of the joint ventures. We may not be able to achieve these objectives in one or more of our joint ventures, which could adversely affect our operating results and cash flows.

If our service providers fail to meet their contractual obligations to us or to comply with applicable laws or regulations, we may be exposed to brand and reputational harm, litigation and/or regulatory action. This risk is particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs.

We contract with various third parties to perform certain functions and services and provide us with certain information technology systems. Our arrangements with these third parties may expose us to public scrutiny, adversely affect our brand and reputation, expose us to litigation or regulatory action, and otherwise make our operations vulnerable if we fail to adequately oversee, monitor and regulate their performance or if they fail to meet their contractual obligations to us or to comply with applicable laws or regulations. For example, certain of our vendors have been responsible for releases of sensitive information of our members and employees, which has caused us to incur additional expenses and given rise to regulatory actions and litigation against us.

These risks are particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs, where third parties perform medical management and other member related services for us. Any failure of our or these third parties' prevention, detection or control systems related to regulatory compliance, compliance with our internal policies, data security and/or cybersecurity or any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, members', customers' or other constituents' sensitive information could require us to expend significant resources to remediate any damage, interrupt our operations and adversely affect our brand and reputation and also expose us to whistleblower, class action and other litigation, other proceedings, prohibitions on marketing or active or passive enrollment of members, corrective actions, fines, sanctions and/or penalties, any of which could adversely affect our businesses, operating results, cash flows and/or financial condition.

We may experience increased medical and other benefit costs, litigation risk and customer and member dissatisfaction when providers that do not have contracts with us render services to our Health Care Benefits members.

Some providers that render services to our Health Care Benefits members do not have contracts with us. In those cases, we do not have a pre-established understanding with these providers as to the amount of compensation that is due to them for services rendered to our members. In some states, the amount of compensation due to these nonparticipating providers is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover the difference between what we have paid them and the amount they charged us from our members, which may result in customer and member dissatisfaction. For example, in October 2018, an arbitrator awarded certain claimant hospitals approximately $150 million in a proceeding relating to Aetna's out-of-network benefit payment and administration practices, and in March 2019 that award was reduced to approximately $86 million. Such disputes may cause us to pay higher medical or other benefit costs than we projected.

Continuing consolidation and integration among providers and other suppliers may increase our medical and other covered benefits costs, make it difficult for us to compete in certain geographies and create new competitors.

Hospitals and other providers and health systems continue to consolidate across the health care industry. While this consolidation could increase efficiency and has the potential to improve the delivery of health care services, it also reduces competition and the number of potential contracting parties in certain geographies. These health systems also are increasingly forming and considering forming health plans to directly offer health insurance in competition with us, a process that has been accelerated by the ACA. In addition, ACOs (including Commercial and Medicaid-only ACOs developed as a result of state Medicaid laws), practice management companies, consolidation among and by integrated health systems and other changes in the organizational structures that physicians, hospitals and other providers adopt continues to change the way these providers interact with us and the competitive landscape in which we operate. These changes may increase our medical and other covered benefits costs, may affect the way we price our products and services and estimate our medical and other covered benefits costs and may require us to change our operations, including by withdrawing from certain geographies where we do not have a significant presence

across our businesses or are unable to collaborate or contract with providers on acceptable terms. Each of these changes may adversely affect our businesses and operating results.

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Item 1B. Unresolved Staff Comments.

There are no unresolved SEC Staff Comments.

Item 2. Properties.

The Company's principal office is an owned building complex located in Woonsocket, Rhode Island, which totals approximately one million square feet. The Company also leases office space in other locations in the United States.

Pharmacy Services Segment

The Pharmacy Services segment includes owned or leased mail service dispensing pharmacies, call centers, on-site pharmacy stores, retail specialty pharmacy stores, specialty mail service pharmacies and branches for infusion and enteral services throughout the United States.

Retail/LTC Segment

As of December 31, 2020, the Retail/LTC segment operated the following properties:

- Approximately 8,115 retail stores, of which approximately 5% were owned. Net selling space for retail stores was approximately 80.1 million square feet as of December 31, 2020.
- Approximately 1,845 retail pharmacies within retail chains, as well as approximately 80 clinics in Target Corporation ("Target") stores;
- Owned distribution centers and leased distribution facilities throughout the United States totaling approximately 10.5 million square feet; and
- Owned and leased LTC pharmacies throughout the United States and an owned LTC repackaging facility.

In connection with certain business dispositions completed between 1995 and 1997, the Company continues to guarantee lease obligations for 76 former stores. The Company is indemnified for these guarantee obligations by the respective initial purchasers. These guarantees generally remain in effect for the initial lease term and any extension thereof pursuant to a renewal option provided for in the lease prior to the time of the disposition. For additional information on these guarantees, see "Lease Guarantees" in Note 16 ''Commitments and Contingencies'' included in Item 8 of this 10-K.

Health Care Benefits Segment

The Health Care Benefits segment's principal office is an owned building complex located in Hartford, Connecticut, which totals approximately 1.7 million square feet. The Health Care Benefits segment also owns or leases office space in other locations in the United States and several other countries.

Management believes that the Company's owned and leased facilities are suitable and adequate to meet the Company's anticipated needs. At the end of the existing lease terms, management believes the leases can be renewed or replaced by alternative space. For additional information on the right-of-use assets and lease liabilities associated with the Company's leases, see Note 6 ''Leases'' included in Item 8 of this 10-K.

Item 3. Legal Proceedings.

I. Legal Proceedings

The information contained in Note 16 ''Commitments and Contingencies'' included in Item 8 of this 10-K is incorporated herein by reference.

II. Environmental Matters

Item 103 of SEC Regulation S-K requires disclosure of environmental legal proceedings with a governmental authority if management reasonably believes that the proceedings involve potential monetary sanctions of $1 million or more.

The Company is in the process of negotiating with the New York State Department of Environmental Conservation to resolve claims of alleged historical noncompliance with hazardous waste regulations in connection with LTC pharmacies in the State of New York. These proceedings are not material to the Company's business or financial condition.

Item 4. Mine Safety Disclosures.

Not applicable.

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Information about our Executive Officers

The following sets forth the name, age and biographical information for each of the Registrant's executive officers as of February 16, 2021. In each case the officer's term of office extends to the date of the meeting of the Board following the next annual meeting of stockholders of CVS Health. Previous positions and responsibilities held by each of the executive officers over the past five years or more are indicated below:

Eva C. Boratto, age 54, Executive Vice President and Chief Financial Officer of CVS Health Corporation since November 2018; Executive Vice President - Controller and Chief Accounting Officer of CVS Health Corporation from March 2017 through November 2018; Senior Vice President - Controller and Chief Accounting Officer of CVS Health Corporation from July 2013 through February 2017. Ms. Boratto is also a member of the board of directors of United Parcel Service, Inc., an international package delivery and supply chain management company.

Troyen A. Brennan, M.D., age 66, Executive Vice President and Chief Medical Officer of CVS Health Corporation since November 2008; Executive Vice President and Chief Medical Officer of Aetna Inc. from February 2006 through November 2008.

James D. Clark, age 56, Senior Vice President - Controller and Chief Accounting Officer of CVS Health Corporation since November 2018; Vice President - Finance and Accounting of CVS Pharmacy, Inc. from September 2009 through October 2018.

Daniel P. Finke, age 50, Executive Vice President of CVS Health Corporation and President of Health Care Benefits since February 2021; Executive Vice President, Commercial Business and Markets of Aetna from February 2020 through January 2021; Executive Vice President, Consumer Health and Service of Aetna from June 2018 through January 2020; Senior Vice President, Network and Clinical Services of Aetna from January 2016 through May 2018.

Laurie P. Havanec, age 60, Executive Vice President and Chief People Officer of CVS Health Corporation since February 2021; Executive Vice President and Chief People Officer, Otis Worldwide Corporation, an elevator, escalator and moving walkway manufacturer, from October 2019 through January 2021; Corporate Vice President, Talent of United Technologies Corporation, a multinational manufacturing conglomerate, from April 2019 through October 2019; Vice President - HR, Institution Businesses of Aetna from 2013 through March 2017.

Alan M. Lotvin, M.D., age 59, Executive Vice President of CVS Health Corporation and President of CVS Caremark since March 2020; Executive Vice President - Transformation of CVS Health Corporation from June 2018 through February 2020; Executive Vice President - Specialty Pharmacy, CVS Caremark from November 2012 through May 2018.

Karen S. Lynch, age 58, President and Chief Executive Officer of CVS Health Corporation since February 2021; Executive Vice President of CVS Health Corporation from November 2018 through January 2021; President of Aetna from January 2015 through January 2021; Executive Vice President, Local and Regional Businesses of Aetna from February 2013 through December 2014; and a director of CVS Health Corporation since February 2021. Ms. Lynch is also a member of the board of directors of U.S. Bancorp, a banking and financial services company.

Neela Montgomery, age 46, Executive Vice President of CVS Health Corporation and President of Retail/ Pharmacy since November 2020; Chief Executive Officer of Crate & Barrel Holdings, a retailer of furniture, kitchenware and other home essentials, from August 2017 through August 2020; Executive Board Member of Otto Group GmbH, a German e-commerce company, from November 2014 through July 2017. Ms. Montgomery is also a member of the board of directors of Logitech International SA, a Swiss-American manufacturer of computer peripherals and software.

Thomas M. Moriarty, age 57, Executive Vice President and General Counsel of CVS Health Corporation since October 2012; Chief Policy and External Affairs Officer since March 2017; Chief Strategy Officer from March 2014 through February 2017.

Jonathan C. Roberts, age 65, Executive Vice President and Chief Operating Officer of CVS Health Corporation since March 2017; Executive Vice President of CVS Health Corporation and President of CVS Caremark from September 2012 through February 2017.

PART II

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

Market Information

CVS Health's common stock is listed on the New York Stock Exchange under the symbol "CVS."

Dividends

CVS Health has paid cash dividends every quarter since becoming a public company. Future dividends will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

See Note 12 ''Shareholders' Equity'' included in Item 8 of this 10-K for information regarding CVS Health's dividends.

Holders of Common Stock

As of February 8, 2021, there were 26,078 registered holders of the registrant's common stock according to the records maintained by the registrant's transfer agent.

Issuer Purchases of Equity Securities

The following share repurchase program has been authorized by the Board:

In billions			**Remaining as of December 31, 2020**
Authorization Date		**Authorized**	
November 2, 2016 ("2016 Repurchase Program")	$	15.0	$ 13.9

The 2016 Repurchase Program permits the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase transactions, and/or other derivative transactions. The 2016 Repurchase Program can be modified or terminated by the Board at any time. During the three months ended December 31, 2020, the Company did not repurchase any shares of common stock.

See Note 12 ''Shareholders' Equity'' included in Item 8 of this 10-K for additional information regarding the Company's share repurchases.

Stock Performance Graph

The following graph compares the cumulative total shareholder return on CVS Health's common stock (assuming reinvestment of dividends) with the cumulative total return on the S&P 500 Index, the S&P 500 Food and Staples Retailing Industry Group Index and the S&P 500 Healthcare Sector Group Index from December 31, 2015 through December 31, 2020. The graph assumes a $100 investment in shares of CVS Health's common stock on December 31, 2015.

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	December 31,					
	2015	2016	2017	2018	2019	2020
CVS Health Corporation	$ 100	$ 82	$ 77	$ 72	$ 84	$ 80
S&P 500 [1]	100	112	136	130	171	203
S&P 500 Food & Staples Retail Group Index [2]	100	99	113	114	145	169
S&P 500 Health Care Group Index [1] [3]	100	97	119	126	153	173

(1) Includes CVS Health.
(2) Includes five companies (COST, KR, SYY, WBA, WMT).
(3) Includes 63 companies.

The year-ended values of each investment shown in the preceding graph are based on share price appreciation plus dividends, with the dividends reinvested as of the last business day of the month during which such dividends were ex-dividend. The calculations exclude trading commissions and taxes. Total shareholder returns from each investment can be calculated from the year-end investment values shown beneath the graph.

Item 6. Reserved

Not applicable.

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Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations. ("MD&A")

The following discussion and analysis should be read in conjunction with the audited consolidated financial statements and related notes included in Item 8 of this 10-K, "Risk Factors" included in Item 1A of this 10-K and the "Cautionary Statement Concerning Forward-Looking Statements" in this 10-K.

Overview of Business

CVS Health Corporation ("CVS Health"), together with its subsidiaries (collectively, the "Company," "we," "our" or "us"), is a diversified health services company united around a common purpose of helping people on their path to better health. In an increasingly connected and digital world, we are meeting people wherever they are and changing health care to meet their needs. The Company has more than 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 105 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year and expanding specialty pharmacy services. We also serve an estimated 34 million people through traditional, voluntary and consumer-directed health insurance products and related services, including expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

On November 28, 2018 (the "Aetna Acquisition Date"), the Company acquired Aetna Inc. ("Aetna"). As a result of the acquisition of Aetna (the "Aetna Acquisition"), the Company added the Health Care Benefits segment. Certain aspects of Aetna's operations, including products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, are included in the Company's Corporate/Other segment. The consolidated financial statements reflect Aetna's results subsequent to the Aetna Acquisition Date.

The Company has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other, which are described below.

Overview of the Pharmacy Services Segment

The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services, mail order pharmacy, specialty pharmacy and infusion services, clinical services, disease management services and medical spend management. The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Medicaid managed care plans, plans offered on public health insurance exchanges and private health insurance exchanges and other sponsors of health benefit plans throughout the United States. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services.

Overview of the Retail/LTC Segment

The Retail/LTC segment sells prescription drugs and a wide assortment of health and wellness products and general merchandise, provides health care services through its MinuteClinic® walk-in medical clinics, provides medical diagnostic testing, administers vaccinations for illnesses such as influenza, COVID-19 and shingles and conducts long-term care pharmacy ("LTC") operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to long-term care facilities and other care settings. As of December 31, 2020, the Retail/LTC segment operated more than 9,900 retail locations, approximately 1,100 MinuteClinic locations as well as online retail pharmacy websites, LTC pharmacies and on-site pharmacies. For the year ended December 31, 2020, the Company dispensed approximately 27.1% of the total retail pharmacy prescriptions in the United States.

Overview of the Health Care Benefits Segment

The Health Care Benefits segment is one of the nation's leading diversified health care benefits providers. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care

professionals, make more informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental and behavioral health plans, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services and health information technology products and services. The Health Care Benefits

segment also provided workers' compensation administrative services through its Coventry Health Care Workers' Compensation business ("Workers' Compensation business") prior to the sale of this business on July 31, 2020. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates. The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk for medical and dental care costs) as "ASC." For periods prior to the Aetna Acquisition Date, the Health Care Benefits segment was comprised only of the Company's SilverScript® PDP business.

Overview of the Corporate/Other Segment

The Company presents the remainder of its financial results in the Corporate/Other segment, which primarily consists of:

- Management and administrative expenses to support the Company's overall operations, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments, expenses associated with the Company's investments in its transformation and enterprise modernization programs and acquisition-related transaction and integration costs; and
- Products for which the Company no longer solicits or accepts new customers such as large case pensions and long-term care insurance products.

COVID-19

The COVID-19 pandemic has severely impacted the economies of the U.S. and other countries around the world. Beginning in March 2020, the effects of the COVID-19 pandemic began to emerge in the U.S. The Company executed preparedness plans to maintain continuity of its operations, including transitioning many office-based colleagues to a remote work environment and installing protective equipment in our retail pharmacies. The Company also provided enhanced benefits to its colleagues, including bonuses to frontline colleagues, dependent care financial assistance, paid sick leave for part-time colleagues and paid time off to colleagues who test positive or are quarantined due to exposure to COVID-19. Our strong local presence and scale in communities across the country enabled us to play an indispensable role in the national response to COVID-19, as well as provide seamless support for our customers wherever they needed us: in our CVS locations, in their homes, and virtually. The COVID-19 pandemic had a significant impact on the Company's operating results for the year ended December 31, 2020, primarily in the Company's Health Care Benefits and Retail/LTC segments.

Health Care Benefits Segment

Beginning in mid-March, the health system experienced a significant reduction in utilization of medical services ("utilization") that is discretionary and the cancellation of elective medical procedures. Utilization remained below historical levels through April, began to recover in May and June and reached more normal levels in the third and fourth quarters, with select geographies impacted by COVID-19 waves.

In response to COVID-19, the Company expanded benefit coverage to its members. These expanded benefits included cost-sharing waivers for COVID-19 related treatments, as well as assistance to members through premium credits, telehealth cost-sharing waivers and other investments.

COVID-19 also resulted in a shift in the Company's medical membership during the year. The Company experienced declines in Commercial membership due to reductions in workforce at our existing customers, substantially offset by increases in Medicaid membership primarily as a result of the suspension of eligibility redeterminations and increased unemployment.

Retail/LTC Segment

During March 2020, the Company experienced increased prescription volume due to the greater use of 90-day prescriptions and early refills of maintenance medications, as well as increased front store volume as consumers prepared for the COVID-19 pandemic. Beginning in the second quarter and continuing throughout the remainder of the year, the Company experienced reduced customer traffic in its retail pharmacies and MinuteClinic locations due to shelter-in-place orders as well as reduced new therapy prescriptions and decreased long-term care prescription volume as a result of the COVID-19 pandemic. In addition, the Company incurred incremental operating expenses associated with the Company's COVID-19 pandemic response efforts and waived fees associated with prescription home delivery and associated front store products.

During 2020, the Company also played a key role in supporting the local communities in which it operates. The Company offered COVID-19 diagnostic testing at more than 4,000 CVS Pharmacy locations as of December 31, 2020. In addition, the Company launched critical diagnostic testing for the vulnerable senior population in long-term care facilities in partnership with three states. The Company was also selected to administer COVID-19 vaccines in both long-term care facilities and its retail pharmacies. The Company began administering COVID-19 vaccinations in long-term care facilities and in certain of its retail pharmacies during December 2020 and February 2021, respectively, and expects to play a significant role in COVID-19 vaccine administration in the future.

The COVID-19 pandemic continues to evolve. We believe COVID-19's impact on our businesses, operating results, cash flows and/or financial condition primarily will be driven by the geographies impacted and the severity and duration of the pandemic; the pandemic's impact on the U.S. and global economies and consumer behavior and health care utilization patterns; and the timing, scope and impact of stimulus legislation as well as other federal, state and local governmental responses to the pandemic. Those primary drivers are beyond our knowledge and control. As a result, the impact COVID-19 will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be adverse and material.

Results of Operations

The following information summarizes the Company's results of operations for 2020 compared to 2019. For discussion of the Company's results of operations for 2019 compared to 2018, see "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2019 filed with the U.S. Securities and Exchange Commission (the "SEC") on February 18, 2020.

Summary of Consolidated Financial Results

				Change			
	Year Ended December 31,			2020 vs. 2019		2019 vs. 2018	
In millions	**2020**	**2019**	**2018**	**$**	**%**	**$**	**%**
Revenues:							
Products	$190,688	$185,236	$183,910	$ 5,452	2.9 %	$ 1,326	0.7 %
Premiums	69,364	63,122	8,184	6,242	9.9 %	54,938	671.3 %
Services	7,856	7,407	1,825	449	6.1 %	5,582	305.9 %
Net investment income	798	1,011	660	(213)	(21.1)%	351	53.2 %
Total revenues	268,706	256,776	194,579	11,930	4.6 %	62,197	32.0 %
Operating costs:							
Cost of products sold	163,981	158,719	156,447	5,262	3.3 %	2,272	1.5 %
Benefit costs	55,679	52,529	6,594	3,150	6.0 %	45,935	696.6 %
Goodwill impairments	—	—	6,149	—	— %	(6,149)	(100.0)%
Operating expenses	35,135	33,541	21,368	1,594	4.8 %	12,173	57.0 %
Total operating costs	254,795	244,789	190,558	10,006	4.1 %	54,231	28.5 %
Operating income	13,911	11,987	4,021	1,924	16.1 %	7,966	198.1 %
Interest expense	2,907	3,035	2,619	(128)	(4.2)%	416	15.9 %
Loss on early extinguishment of debt	1,440	79	—	1,361	1,722.8 %	79	— %
Other income	(206)	(124)	(4)	(82)	(66.1)%	(120)	(3,000.0)%
Income before income tax provision	9,770	8,997	1,406	773	8.6 %	7,591	539.9 %
Income tax provision	2,569	2,366	2,002	203	8.6 %	364	18.2 %
Income (loss) from continuing operations	7,201	6,631	(596)	570	8.6 %	7,227	1,212.6 %
Loss from discontinued operations, net of tax	(9)	—	—	(9)	— %	—	— %
Net income (loss)	7,192	6,631	(596)	561	8.5 %	7,227	1,212.6 %
Net (income) loss attributable to noncontrolling interests	(13)	3	2	(16)	(533.3)%	1	50.0 %
Net income (loss) attributable to CVS Health	$ 7,179	$ 6,634	$ (594)	$ 545	8.2 %	$ 7,228	1,216.8 %

Commentary - 2020 compared to 2019

Revenues

- Total revenues increased $11.9 billion or 4.6% in 2020 compared to 2019. The increase in total revenues was primarily driven by growth in the Health Care Benefits and Retail/LTC segments.
- Please see "Segment Analysis" later in this MD&A for additional information about the revenues of the Company's segments.

Operating expenses

- Operating expenses increased $1.6 billion or 4.8% in 2020 compared to 2019. Operating expenses as a percentage of total revenues remained consistent at 13.1% in both 2020 and 2019. The increase in operating expenses was primarily due to the reinstatement of the non-deductible health insurer fee ("HIF") which was $1.0 billion for 2020, incremental operating expenses associated with the Company's COVID-19 pandemic response efforts and increased operating expenses associated with growth in the business. The increase in operating expenses was partially offset by (i) a $269 million pre-tax gain on the sale of the Workers' Compensation business, which occurred on July 31, 2020, (ii) the absence of $231 million of store rationalization charges and a $205 million pre-tax loss on the sale of the Company's Brazilian subsidiary, Drogaria

Onofre Ltda. ("Onofre"), both recorded in the year ended December 31, 2019, and (iii) the favorable impact of enterprise-wide cost savings initiatives in 2020.

- Please see "Segment Analysis" later in this MD&A for additional information about the operating expenses of the Company's segments.

Operating income

- Operating income increased $1.9 billion or 16.1% in 2020 compared to 2019. The increase in operating income was primarily due to:
    - Increased operating income in the Health Care Benefits segment, primarily as a result of the COVID-19 pandemic, pre-tax income of $307 million associated with the receipt of amounts owed to the Company under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA") risk corridor program that was previously fully reserved for as payment was uncertain, and the $269 million pre-tax gain on the sale of the Workers' Compensation business;
    - Increased operating income in the Pharmacy Services segment, primarily related to improved purchasing economics; and
    - The favorable impact of enterprise-wide cost savings initiatives in 2020, partially offset by:
    - Decreased operating income in the Retail/LTC segment, primarily as a result of continued reimbursement pressure and the net adverse impact of the COVID-19 pandemic, partially offset by the absence of $231 million of store rationalization charges and the $205 million pre-tax loss on the sale of Onofre, both recorded in 2019.
- Please see "Segment Analysis" later in this MD&A for additional information about the operating income of the Company's segments.

Interest expense

- Interest expense decreased $128 million in 2020 compared to 2019, primarily due to lower average debt in 2020. See "Liquidity and Capital Resources" later in this report for additional information.

Loss on early extinguishment of debt

- During 2020, the loss on early extinguishment of debt relates to the Company's repayment of $6.0 billion of its outstanding senior notes pursuant to its tender offers for such senior notes in August 2020, which resulted in a loss on early extinguishment of debt of $766 million, and the repayment of $4.5 billion of its outstanding senior notes pursuant to its tender offers for such senior notes in December 2020, which resulted in a loss on early extinguishment of debt of $674 million. During 2019, the loss on early extinguishment of debt relates to the Company's repayment of $4.0 billion of its outstanding senior notes pursuant to its tender offers for such senior notes in August 2019, which resulted in a loss on early extinguishment of debt of $79 million. See Note 8 "Borrowings and Credit Agreements" included in Item 8 of this 10-K for additional information.

Other income

- Other income increased $82 million in 2020 compared to 2019. Other income represents pension plan asset returns in excess of interest cost on pension plan obligations. The increase in other income in 2020 was primarily due to lower discount rates in 2020 compared to 2019 when determining the interest cost on the Company's pension plan obligations as well as strong plan asset returns.

Income tax provision

- The Company's effective income tax rate remained consistent at 26.3% in both 2020 and 2019, with the impact of the non-deductible HIF offset by the favorable resolution of certain tax matters in the year ended December 31, 2020.

Loss from discontinued operations

- In connection with certain business dispositions completed between 1995 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Linens 'n Things and Bob's Stores, each of which subsequently filed for bankruptcy. The Company's loss from discontinued operations in 2020 primarily includes lease-related costs required to satisfy these lease guarantees.

- See “Discontinued Operations” in Note 1 ‘‘Significant Accounting Policies’’ and “Lease Guarantees” in Note 16 ‘‘Commitments and Contingencies’’ included in Item 8 of this 10-K for additional information about the Company’s discontinued operations and the Company’s lease guarantees, respectively.

Outlook for 2021

With respect to 2021, the Company believes you should consider the following important information:

- The Pharmacy Services segment is expected to benefit from continued growth in specialty pharmacy and our ability to drive further improvements in purchasing economics, partially offset by continued price compression.
- The Retail/LTC segment is expected to benefit from increased prescription volume, diagnostic testing and improved generic drug purchasing, partially offset by continued reimbursement pressure and operating expenses associated with the Company's COVID-19 pandemic response efforts. The projected adjusted prescription growth is expected to be driven by the continued successful execution of our patient care programs, the anticipated return of provider visits as we move through the year and vaccination administration. While lower front store traffic has persisted into the first quarter of 2021, we expect front store traffic to increase as we move through the year.
- The Health Care Benefits segment is expected to benefit from Medicare membership growth, partially offset by membership declines in our Medicaid products, the adverse impact of the COVID-19 pandemic and the removal of the HIF. The projected MBR is expected to increase compared to 2020, reflecting the return to more normal levels of utilization, the removal of the HIF, lower Medicare risk adjustment revenue and the continued shift in business mix. The COVID-19 pandemic is expected to adversely impact earnings in 2021 due to the regulatory changes included in the Consolidated Appropriations Act of 2021; testing, treatment and vaccination costs; and lower Medicare risk adjustment revenue.
- The Company is expected to benefit from the continuation of its enterprise-wide cost savings initiatives that are expected to ramp as we move through the year. Key drivers include:
    - The ongoing digitalization of our business along with technology improvements in our operations,
    - Office real estate reductions associated with workforce management changes and
    - Productivity/operational efficiency initiatives within each of the Company's segments.
- Based upon current tax legislation, the Company expects its effective income tax rate to decrease primarily due to the removal of the HIF in 2021.
- The Company expects changes to its business environment to continue as elected and other government officials at the national and state levels continue to propose and enact significant modifications to public policy and existing laws and regulations that govern or impact the Company's businesses.

The Company's current expectations described above are forward-looking statements. Please see "Risk Factors" included in Item 1A of this 10-K and the "Cautionary Statement Concerning Forward-Looking Statements" in this 10-K for information regarding important factors that may cause the Company's actual results to differ from those currently projected and/or otherwise materially affect the Company.

Segment Analysis

The following discussion of segment operating results is presented based on the Company's reportable segments in accordance with the accounting guidance for segment reporting and is consistent with the segment disclosure in Note 17 "Segment Reporting" included in Item 8 of this 10-K.

The Company has three operating segments, Pharmacy Services, Retail/LTC and Health Care Benefits, as well as a Corporate/Other segment. The Company's segments maintain separate financial information, and the Company's chief operating decision maker ("CODM") evaluates the segments' operating results on a regular basis in deciding how to allocate resources among the segments and in assessing segment performance. The CODM evaluates the performance of the Company's segments based on adjusted operating income, which is defined as operating income (GAAP measure) excluding the impact of amortization of intangible assets and other items, if any, that neither relate to the ordinary course of the Company's business nor reflect the Company's underlying business performance. See the reconciliations of operating income (GAAP measure) to adjusted operating income below for further context regarding the items excluded from operating income in determining adjusted operating income. The Company uses adjusted operating income as its principal measure of segment performance as it enhances the Company's ability to compare past financial performance with current performance and analyze underlying business performance and trends. Non-GAAP financial measures the Company discloses, such as consolidated adjusted operating income, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

The following is a reconciliation of financial measures of the Company's segments to the consolidated totals:

In millions	**Pharmacy Services [1]**	**Retail/ LTC**	**Health Care Benefits**	**Corporate/ Other**	**Intersegment Eliminations [2]**	**Consolidated Totals**
2020						
Total revenues	$ 141,938	$ 91,198	$ 75,467	$ 426	$ (40,323)	$ 268,706
Adjusted operating income (loss)	5,688	6,146	6,188	(1,306)	(708)	16,008
2019						
Total revenues	141,491	86,608	69,604	512	(41,439)	256,776
Adjusted operating income (loss)	5,129	6,705	5,202	(1,000)	(697)	15,339
2018						
Total revenues	134,736	83,989	8,962	606	(33,714)	194,579
Adjusted operating income (loss)	4,955	7,403	528	(856)	(769)	11,261

(1) Total revenues of the Pharmacy Services segment include approximately $10.9 billion, $11.5 billion and $11.4 billion of retail co-payments for 2020, 2019 and 2018, respectively. See Note 1 "Significant Accounting Policies" included in Item 8 of this 10-K for additional information about retail co-payments.

(2) Intersegment eliminations relate to intersegment revenue generating activities that occur between the Pharmacy Services segment, the Retail/ LTC segment and/or the Health Care Benefits segment.

The following are reconciliations of operating income to adjusted operating income for the years ended December 31, 2020, 2019 and 2018:

	Year Ended December 31, 2020					
In millions	**Pharmacy Services**	**Retail/ LTC**	**Health Care Benefits**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Operating income (loss) (GAAP measure)	$ 5,454	$ 5,640	$ 5,166	$ (1,641)	$ (708)	$ 13,911
Non-GAAP adjustments:						
Amortization of intangible assets [1]	234	506	1,598	3	—	2,341
Acquisition-related integration costs [2]	—	—	—	332	—	332
Gain on divestiture of subsidiary [3]	—	—	(269)	—	—	(269)
Receipt of fully reserved ACA risk corridor receivable [4]	—	—	(307)	—	—	(307)
Adjusted operating income (loss)	$ 5,688	$ 6,146	$ 6,188	$ (1,306)	$ (708)	$ 16,008

	Year Ended December 31, 2019					
In millions	**Pharmacy Services**	**Retail/ LTC**	**Health Care Benefits**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Operating income (loss) (GAAP measure)	$ 4,735	$ 5,793	$ 3,639	$ (1,483)	$ (697)	$ 11,987
Non-GAAP adjustments:						
Amortization of intangible assets [1]	394	476	1,563	3	—	2,436
Acquisition-related integration costs [2]	—	—	—	480	—	480
Loss on divestiture of subsidiary [3]	—	205	—	—	—	205
Store rationalization charges [5]	—	231	—	—	—	231
Adjusted operating income (loss)	$ 5,129	$ 6,705	$ 5,202	$ (1,000)	$ (697)	$ 15,339

	Year Ended December 31, 2018					
In millions	**Pharmacy Services**	**Retail/ LTC**	**Health Care Benefits**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Operating income (loss) (GAAP measure)	$ 4,607	$ 620	$ 368	$ (805)	$ (769)	$ 4,021
Non-GAAP adjustments:						
Amortization of intangible assets [1]	348	498	160	—	—	1,006
Acquisition-related transaction and integration costs [2]	—	7	—	485	—	492
Loss on divestiture of subsidiary [3]	—	86	—	—	—	86
Goodwill impairments [6]	—	6,149	—	—	—	6,149
Impairment of long-lived assets [7]	—	43	—	—	—	43
Interest income on financing for the Aetna Acquisition [8]	—	—	—	(536)	—	(536)
Adjusted operating income (loss)	$ 4,955	$ 7,403	$ 528	$ (856)	$ (769)	$ 11,261

(1) The Company's acquisition activities have resulted in the recognition of intangible assets as required under the acquisition method of accounting which consist primarily of trademarks, customer contracts/relationships, covenants not to compete, technology, provider networks and value of business acquired. Definite-lived intangible assets are amortized over their estimated useful lives and are tested for impairment when events indicate that the carrying value may not be recoverable. The amortization of intangible assets is reflected in the Company's statements of operations in operating expenses within each segment. Although intangible assets contribute to the Company's revenue generation, the amortization of intangible assets does not directly relate to the underwriting of the Company's insurance products, the services performed for the Company's customers or the sale of the Company's products or services. Additionally, intangible asset amortization expense typically fluctuates based on the size and timing of the Company's acquisition activity. Accordingly, the Company believes excluding the amortization of intangible assets enhances the Company's and investors' ability to compare the Company's past financial performance with its current performance and to analyze underlying business performance and trends. Intangible asset amortization excluded from the related non-GAAP financial measure represents the entire amount recorded within the Company's GAAP financial statements, and the revenue generated by the associated intangible assets has not been excluded from the related non-GAAP financial measure. Intangible asset amortization is excluded from the related non-GAAP financial measure because the amortization, unlike the related revenue, is not affected by operations of any particular period unless an intangible asset becomes impaired or the estimated useful life of an intangible asset is revised.

(2) In 2020, 2019 and 2018, acquisition-related transaction and integration costs relate to the Aetna Acquisition. In 2018, acquisition-related integration costs also relate to the acquisition of Omnicare, Inc. ("Omnicare"). The acquisition-related transaction and integration costs are reflected in the Company's consolidated statements of operations in operating expenses within the Corporate/Other segment and the Retail/LTC segment.

(3) In 2020, the gain on divestiture of subsidiary represents the pre-tax gain on the sale of the Workers' Compensation business, which the Company sold on July 31, 2020 for approximately $850 million. The gain on divestiture is reflected as a reduction in operating expenses in the Company's consolidated statement of operations within the Health Care Benefits segment. In 2019, the loss on divestiture of subsidiary represents the pre-tax loss on the sale of Onofre, which occurred on July 1, 2019. The loss on divestiture primarily relates to the elimination of the cumulative translation adjustment from accumulated other comprehensive income. In 2018, the loss on divestiture of subsidiary represents the pre-tax loss on the sale of the Company's RxCrossroads subsidiary for $725 million on January 2, 2018. The losses on divestiture in 2019 and 2018 are reflected in the Company's consolidated statements of operations in operating expenses within the Retail/LTC segment.

(4) In 2020, the Company received $313 million owed to it under the ACA's risk corridor program that was previously fully reserved for as payment was uncertain. After considering offsetting items such as the ACA's minimum medical loss ratio ("MLR") rebate requirements and premium taxes, the Company recognized pre-tax income of $307 million in the Company's consolidated statement of operations within the Health Care Benefits segment.

(5) In 2019, the store rationalization charges relate to the planned closure of 46 underperforming retail pharmacy stores in the second quarter of 2019 and the planned closure of 22 underperforming retail pharmacy stores in the first quarter of 2020. The store rationalization charges primarily relate to operating lease right-of-use asset impairment charges and are reflected in the Company's consolidated statement of operations in operating expenses within the Retail/LTC segment.

(6) In 2018, the goodwill impairments relate to the LTC reporting unit within the Retail/LTC segment.

(7) In 2018, impairment of long-lived assets primarily relates to the impairment of property and equipment within the Retail/LTC segment and is reflected in operating expenses in the Company's consolidated statement of operations.

(8) In 2018, the Company recorded interest income of $536 million on the proceeds of the $40 billion of unsecured senior notes it issued in March 2018 to partially fund the Aetna Acquisition. All amounts are for the periods prior to the close of the Aetna Acquisition, which occurred on November 28, 2018, and were recorded within the Corporate/Other segment.

Pharmacy Services Segment

The following table summarizes the Pharmacy Services segment's performance for the respective periods:

				Change			
	Year Ended December 31,			2020 vs. 2019		2019 vs. 2018	
In millions, except percentages	**2020**	**2019**	**2018**	**$**	**%**	**$**	**%**
Revenues:							
Products	$140,950	$140,946	$134,285	$ 4	— %	$ 6,661	5.0 %
Services	988	545	451	443	81.3 %	94	20.8 %
Total revenues	141,938	141,491	134,736	447	0.3 %	6,755	5.0 %
Cost of products sold	135,045	135,245	128,777	(200)	(0.1)%	6,468	5.0 %
Operating expenses	1,439	1,511	1,352	(72)	(4.8)%	159	11.8 %
Operating expenses as a % of total revenues	1.0 %	1.1 %	1.0 %				
Operating income	$ 5,454	$ 4,735	$ 4,607	$ 719	15.2 %	$ 128	2.8 %
Operating income as a % of total revenues	3.8 %	3.3 %	3.4 %				
Adjusted operating income [1]	$ 5,688	$ 5,129	$ 4,955	$ 559	10.9 %	$ 174	3.5 %
Adjusted operating income as a % of total revenues	4.0 %	3.6 %	3.7 %				
Revenues (by distribution channel):							
Pharmacy network [2]	$ 85,045	$ 88,755	$ 87,167	$ (3,710)	(4.2)%	$ 1,588	1.8 %
Mail choice [3]	56,071	52,141	47,049	3,930	7.5 %	5,092	10.8 %
Other	822	595	520	227	38.2 %	75	14.4 %
Pharmacy claims processed: [4]							
Total	2,112.9	2,014.2	1,889.8	98.7	4.9 %	124.4	6.6 %
Pharmacy network [2]	1,790.1	1,704.0	1,601.4	86.1	5.1 %	102.6	6.4 %
Mail choice [3]	322.8	310.2	288.4	12.6	4.1 %	21.8	7.6 %
Generic dispensing rate: [4]							
Total	88.2 %	88.2 %	87.3 %				
Pharmacy network [2]	88.7 %	88.7 %	87.9 %				
Mail choice [3]	85.3 %	85.1 %	83.9 %				

(1) See "Segment Analysis" above in this MD&A for a reconciliation of operating income (GAAP measure) to adjusted operating income for the Pharmacy Services segment.

(2) Pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including the Company's retail pharmacies and LTC pharmacies, but excluding Maintenance Choice® activity, which is included within the mail choice category. Maintenance Choice permits eligible client plan members to fill their maintenance prescriptions through mail order delivery or at a CVS pharmacy retail store for the same price as mail order.

(3) Mail choice is defined as claims filled at a Pharmacy Services mail order facility, which includes specialty mail claims inclusive of Specialty Connect® claims picked up at a retail pharmacy, as well as prescriptions filled at the Company's retail pharmacies under the Maintenance Choice program.

(4) Includes an adjustment to convert 90-day prescriptions to the equivalent of three 30-day prescriptions. This adjustment reflects the fact that these prescriptions include approximately three times the amount of product days supplied compared to a normal prescription.

Commentary - 2020 compared to 2019

Revenues

- Total revenues increased $447 million, or 0.3%, to $141.9 billion in 2020 compared to 2019. The increase was primarily driven by growth in specialty pharmacy and brand inflation, partially offset by continued price compression and changes in net new business mix.

Operating expenses

- Operating expenses in the Pharmacy Services segment include selling, general and administrative expenses; depreciation and amortization expense; and expenses related to specialty retail pharmacies, which include store and administrative payroll, employee benefits and occupancy costs.
- Operating expenses decreased $72 million, or 4.8%, in 2020 compared to 2019 primarily driven by lower amortization expense in 2020, partially offset by incremental operating expenses associated with growth in the business, including investments in the Company's growth initiatives.
- Operating expenses as a percentage of total revenues remained relatively consistent at 1.0% and 1.1% in 2020 and 2019, respectively.

Operating income and adjusted operating income

- Operating income increased $719 million, or 15.2%, and adjusted operating income increased $559 million, or 10.9%, in 2020 compared to 2019. The increase in both operating income and adjusted operating income was primarily driven by improved purchasing economics and growth in specialty pharmacy, partially offset by continued price compression. The increase in operating income also was driven by lower amortization expense in 2020.
- As you review the Pharmacy Services segment's performance in this area, you should consider the following important information about the business:
    - The Company's efforts to (i) retain existing clients, (ii) obtain new business and (iii) maintain or improve the rebates and/or discounts the Company receives from manufacturers, wholesalers and retail pharmacies continue to have an impact on operating income and adjusted operating income. In particular, competitive pressures in the PBM industry have caused the Company and other PBMs to continue to share with clients a larger portion of rebates and/or discounts received from pharmaceutical manufacturers. In addition, marketplace dynamics and regulatory changes have limited the Company's ability to offer plan sponsors pricing that includes retail network "differential" or "spread," and the Company expects these trends to continue. The "differential" or "spread" is any difference between the drug price charged to plan sponsors, including Medicare Part D plan sponsors, by a PBM and the price paid for the drug by the PBM to the dispensing provider.

Pharmacy claims processed

- Total pharmacy claims processed represents the number of prescription claims processed through our pharmacy benefits manager and dispensed by either our retail network pharmacies or our own mail and specialty pharmacies. Management uses this metric to understand variances between actual claims processed and expected amounts as well as trends in period-over-period results. This metric provides management and investors with information useful in understanding the impact of pharmacy claim volume on segment total revenues and operating results.
- The Company's pharmacy network claims processed on a 30-day equivalent basis increased 5.1% to 1.8 billion claims in 2020 compared to 1.7 billion claims in 2019. The increase in pharmacy network claims processed was primarily driven by net new business.
- The Company's mail choice claims processed on a 30-day equivalent basis increased 4.1% to 322.8 million claims in 2020 compared to 310.2 million claims in 2019. The increase in mail choice claims was primarily driven by net new business and the continued adoption of Maintenance Choice offerings.

Generic dispensing rate

- Generic dispensing rate is calculated by dividing the Pharmacy Services segment's generic drug prescriptions processed or filled by its total prescriptions processed or filled. Management uses this metric to evaluate the effectiveness of the business at encouraging the use of generic drugs when they are available and clinically appropriate, which aids in decreasing costs for client members and retail customers. This metric provides management and investors with information useful in understanding trends in segment total revenues and operating results.
- The Pharmacy Services segment's total generic dispensing rate remained consistent at 88.2% in both 2020 and 2019.

Retail/LTC Segment

The following table summarizes the Retail/LTC segment's performance for the respective periods:

				Change			
	Year Ended December 31,			2020 vs. 2019		2019 vs. 2018	
In millions, except percentages	**2020**	**2019**	**2018**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ 89,944	$ 85,729	$ 83,175	$ 4,215	4.9 %	$ 2,554	3.1 %
Services	1,254	879	814	375	42.7 %	65	8.0 %
Total revenues	91,198	86,608	83,989	4,590	5.3 %	2,619	3.1 %
Cost of products sold	67,284	62,688	59,906	4,596	7.3 %	2,782	4.6 %
Goodwill impairments	—	—	6,149	—	— %	(6,149)	(100.0)%
Operating expenses	18,274	18,127	17,314	147	0.8 %	813	4.7 %
Operating expenses as a % of total revenues	20.0 %	20.9 %	20.6 %				
Operating income	$ 5,640	$ 5,793	$ 620	$ (153)	(2.6)%	$ 5,173	834.4 %
Operating income as a % of total revenues	6.2 %	6.7 %	0.7 %				
Adjusted operating income [1]	$ 6,146	$ 6,705	$ 7,403	$ (559)	(8.3)%	$ (698)	(9.4)%
Adjusted operating income as a % of total revenues	6.7 %	7.7 %	8.8 %				
Revenues (by major goods/ service lines):							
Pharmacy	$ 70,176	$ 66,442	$ 64,179	$ 3,734	5.6 %	$ 2,263	3.5 %
Front Store	19,655	19,422	19,055	233	1.2 %	367	1.9 %
Other	1,367	744	755	623	83.7 %	(11)	(1.5)%
Prescriptions filled [2]	1,465.2	1,417.2	1,339.1	48.0	3.4 %	78.1	5.8 %
Same store sales increase: [3]							
Total	5.6 %	3.7 %	6.0 %				
Pharmacy	7.0 %	4.5 %	7.9 %				
Front Store	0.9 %	1.1 %	0.5 %				
Prescription volume [2]	4.7 %	7.2 %	9.1 %				
Generic dispensing rate [2]	88.3 %	88.3 %	87.5 %				

(1) See "Segment Analysis" above in this MD&A for a reconciliation of operating income (GAAP measure) to adjusted operating income for the Retail/LTC segment.

(2) Includes an adjustment to convert 90-day prescriptions to the equivalent of three 30-day prescriptions. This adjustment reflects the fact that these prescriptions include approximately three times the amount of product days supplied compared to a normal prescription.

(3) Same store sales and prescription volume represent the change in revenues and prescriptions filled in the Company's retail pharmacy stores that have been operating for greater than one year, expressed as a percentage that indicates the increase or decrease relative to the comparable prior period. Same store metrics exclude revenues from MinuteClinic, revenues and prescriptions from LTC operations and, in 2019 and 2018, revenues and prescriptions from stores in Brazil. Management uses these metrics to evaluate the performance of existing stores on a comparable basis and to inform future decisions regarding existing stores and new locations. Same-store metrics provide management and investors with information useful in understanding the portion of current revenues and prescriptions resulting from organic growth in existing locations versus the portion resulting from opening new stores.

Commentary - 2020 compared to 2019

Revenues

- Total revenues increased $4.6 billion, or 5.3%, to $91.2 billion in 2020 compared to 2019. The increase was primarily driven by increased prescription volume, COVID-19 diagnostic testing and brand inflation, partially offset by continued reimbursement pressure and the impact of recent generic introductions.

- Pharmacy same store sales increased 7.0% in 2020 compared to 2019. The increase was driven by the 4.7% increase in pharmacy same store prescription volume on a 30-day equivalent basis, pharmacy drug mix and brand inflation. These increases were partially offset by continued reimbursement pressure and the impact of recent generic introductions.

- Front store same store sales increased 0.9% in 2020 compared to 2019. The increase was primarily due to increases in consumer health and general merchandise sales.
- Other revenues increased 83.7% in 2020 compared to 2019. The increase was primarily due to increased diagnostic testing in response to the COVID-19 pandemic in 2020.

Operating expenses

- Operating expenses in the Retail/LTC segment include store payroll, store employee benefits, store occupancy costs, selling expenses, advertising expenses, depreciation and amortization expense and certain administrative expenses.
- Operating expenses increased $147 million, or 0.8%, in 2020 compared to 2019. The increase was primarily due to incremental operating expenses associated with the Company's COVID-19 pandemic response efforts, the increased volume described above and investments in the business in 2020. The increase was partially offset by the absence of $231 million of store rationalization charges in connection with the planned closure of underperforming retail pharmacy stores and the $205 million pre-tax loss on the sale of Onofre, both recorded in 2019, as well as the impact of cost savings initiatives in 2020.
- Operating expenses as a percentage of total revenues decreased to 20.0% in 2020 compared to 20.9% in 2019. The decrease in operating expenses as a percentage of total revenues was primarily driven by the increases in total revenues described above.

Operating income and adjusted operating income

- Operating income decreased $153 million, or 2.6%, and adjusted operating income decreased $559 million, or 8.3%, in 2020 compared to 2019. The decrease in both operating income and adjusted operating income was primarily due to continued reimbursement pressure and the net impact of the COVID-19 pandemic, partially offset by the increased pharmacy volume described above and improved generic drug purchasing. The COVID-19 pandemic resulted in reduced operating income and adjusted operating income in 2020 as a result of decreased customer traffic in the segment's retail pharmacies and MinuteClinic locations and incremental operating expenses associated with the Company's COVID-19 pandemic response efforts, partially offset by COVID-19 diagnostic testing. The decrease in operating income also was partially offset by the absence of the $231 million of store rationalization charges and the $205 million pre-tax loss on the sale of Onofre, both recorded in 2019.
- As you review the Retail/LTC segment's performance in this area, you should consider the following important information about the business:
    - The segment's pharmacy operating income and adjusted operating income have been adversely affected by the efforts of managed care organizations, PBMs and governmental and other third-party payors to reduce their prescription drug costs, including the use of restrictive networks, as well as changes in the mix of business within the pharmacy portion of the Retail/LTC segment. If the reimbursement pressure accelerates, the segment may not be able to grow revenues, and its operating income and adjusted operating income could be adversely affected.
    - The increased use of generic drugs has positively impacted the segment's operating income and adjusted operating income but has resulted in third-party payors augmenting their efforts to reduce reimbursement payments to retail pharmacies for prescriptions. This trend, which the Company expects to continue, reduces the benefit the segment realizes from brand-to-generic drug conversions.

Prescriptions filled

- Prescriptions filled represents the number of prescriptions dispensed through the Retail/LTC segment's pharmacies. Management uses this metric to understand variances between actual prescriptions dispensed and expected amounts as well as trends in period-over-period results. This metric provides management and investors with information useful in understanding the impact of prescription volume on segment total revenues and operating results.
- Prescriptions filled increased 3.4% on a 30-day equivalent basis in 2020 compared to 2019 primarily driven by the continued adoption of patient care programs, partially offset by reduced new therapy prescriptions as a result of the COVID-19 pandemic and decreased long-term care prescription volume.

Generic dispensing rate

- Generic dispensing rate is calculated by dividing the Retail/LTC segment's generic drug prescriptions filled by its total prescriptions filled. Management uses this metric to evaluate the effectiveness of the business at

encouraging the use of generic drugs when they are available and clinically appropriate, which aids in decreasing costs for client members and retail customers. This metric provides management and investors with information useful in understanding trends in segment total revenues and operating results.

- The Retail/LTC segment's generic dispensing rate remained consistent at 88.3% in both 2020 and 2019.

Health Care Benefits Segment

For periods prior to November 28, 2018 (the Aetna Acquisition Date), the Health Care Benefits segment was comprised only of the Company's SilverScript PDP business. The following table summarizes the Health Care Benefits segment's performance for the respective periods:

	Year Ended December 31,			Change			
				2020 vs. 2019		2019 vs. 2018	
In millions, except percentages and basis points ("bps")	**2020**	**2019**	**2018**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ —	$ —	$ 164	$ —	— %	$ (164)	(100.0)%
Premiums	69,301	63,031	8,180	6,270	9.9 %	54,851	670.6 %
Services	5,683	5,974	560	(291)	(4.9)%	5,414	966.8 %
Net investment income	483	599	58	(116)	(19.4)%	541	932.8 %
Total revenues	75,467	69,604	8,962	5,863	8.4 %	60,642	676.7 %
Cost of products sold	—	—	147	—	— %	(147)	(100.0)%
Benefit costs	56,083	53,092	6,678	2,991	5.6 %	46,414	695.0 %
MBR (Benefit costs as a % of premium revenues) [1]	80.9 %	84.2 %	NM	(330) bps		NM	
Operating expenses	$ 14,218	$ 12,873	$ 1,769	$ 1,345	10.4 %	$ 11,104	627.7 %
Operating expenses as a % of total revenues	18.8 %	18.5 %	19.7 %				
Operating income	$ 5,166	$ 3,639	$ 368	$ 1,527	42.0 %	$ 3,271	888.9 %
Operating income as a % of total revenues	6.8 %	5.2 %	4.1 %				
Adjusted operating income [2]	$ 6,188	$ 5,202	$ 528	$ 986	19.0 %	$ 4,674	885.2 %
Adjusted operating income as a % of total revenues	8.2 %	7.5 %	5.9 %				
Premium revenues (by business):							
Government	$ 48,928	$ 41,818	$ 6,091	$ 7,110	17.0 %	$ 35,727	586.6 %
Commercial	20,373	21,213	2,089	(840)	(4.0)%	19,124	915.5 %

(1) For periods prior to the Aetna Acquisition Date, the Health Care Benefits segment was comprised only of the Company's SilverScript PDP business. Accordingly, the MBR for the year ended December 31, 2018 is not meaningful ("NM") and is not directly comparable to the MBRs for the years ended December 31, 2020 and 2019.

(2) See "Segment Analysis" above in this MD&A for a reconciliation of operating income (GAAP measure) to adjusted operating income for the Health Care Benefits segment.

Commentary - 2020 compared to 2019

Revenues

- Total revenues increased $5.9 billion, or 8.4%, to $75.5 billion in 2020 compared to 2019 primarily driven by membership growth in the Health Care Benefits segment's Government products, the favorable impact of the reinstatement of the HIF for 2020 and the receipt of $313 million owed to the Company under the ACA's risk corridor program. These increases were partially offset by the divestitures of Aetna's standalone PDPs (which the Company retained the financial results of through 2019) and Workers' Compensation business, membership declines in the segment's Commercial products and COVID-19 related investments benefiting customers in 2020.

Medical Benefit Ratio ("MBR")

- Medical benefit ratio is calculated as benefit costs divided by premium revenues and represents the percentage of premium revenues spent on medical benefits for the Company's Insured members. Management uses MBR to

assess the underlying business performance and underwriting of its insurance products, understand variances between actual results and expected results and identify trends in period-over-period results. MBR provides management and investors with information useful in assessing the operating results of the Company's Insured Health Care Benefits products.

- The Health Care Benefits segment's MBR decreased 330 basis points from 84.2% to 80.9% in 2020 compared to 2019. The decrease was primarily due to (i) the impact of the COVID-19 pandemic, which resulted in reduced benefit costs due

to the deferral of elective procedures and other discretionary utilization, partially offset by COVID-19 related investments, testing and treatment costs, (ii) the reinstatement of the HIF for 2020 and (iii) the receipt of amounts owed to the Company under the ACA's risk corridor program in 2020.

Operating expenses

- Operating expenses in the Health Care Benefits segment include selling, general and administrative expenses and depreciation and amortization expenses.
- Operating expenses increased $1.3 billion in 2020 compared to 2019. The increase in operating expenses was primarily due to the reinstatement of the HIF which was $1.0 billion for 2020 and incremental operating expenses to support the increased membership described above, including operating expenses to support additional Medicaid members onboarded during the first quarter of 2020. The increase was partially offset by the divestitures of Aetna's standalone PDPs and Workers' Compensation business, the $269 million pre-tax gain on the sale of the Workers' Compensation business and the impact of cost savings initiatives in 2020.

Operating income and adjusted operating income

- Operating income and adjusted operating income increased $1.5 billion and $1.0 billion, respectively, in 2020 compared to 2019. The increase in both operating income and adjusted operating income was primarily driven by the impact of the COVID-19 pandemic, partially offset by the divestitures of Aetna's standalone PDPs and Workers' Compensation business. The COVID-19 pandemic resulted in reduced benefit costs due to the deferral of elective procedures and other discretionary utilization, partially offset by COVID-19 related investments, testing and treatment costs. Operating income also includes pre-tax income of $307 million associated with the receipt of amounts owed to the Company under the ACA's risk corridor program and the $269 million pre-tax gain on the sale of the Workers' Compensation business in 2020.

The following table summarizes the Health Care Benefits segment's medical membership as of December 31, 2020 and 2019:

	2020			2019		
In thousands	**Insured**	**ASC**	**Total**	**Insured**	**ASC**	**Total**
Medical membership:						
Commercial	3,258	13,644	16,902	3,591	14,159	17,750
Medicare Advantage	2,705	—	2,705	2,321	—	2,321
Medicare Supplement	1,082	—	1,082	881	—	881
Medicaid	2,100	623	2,723	1,398	558	1,956
Total medical membership	9,145	14,267	23,412	8,191	14,717	22,908
Supplemental membership information:						
Medicare Prescription Drug Plan (standalone) [(1)]			5,490			5,994

(1) Represents the Company's SilverScript PDP membership only. Excludes 2.5 million members as of December 31, 2019 related to Aetna's standalone PDPs that were sold effective December 31, 2018. The Company retained the financial results of the divested plans through 2019 through a reinsurance agreement. Subsequent to 2019, the Company no longer retains the financial results of the divested plans.

Medical Membership

- Medical membership represents the number of members covered by the Company's Insured and ASC medical products and related services at a specified point in time. Management uses this metric to understand variances between actual medical membership and expected amounts as well as trends in period-over-period results. This metric provides management and investors with information useful in understanding the impact of medical membership on segment total revenues and operating results.
- Medical membership as of December 31, 2020 of 23.4 million increased 504 thousand compared with December 31, 2019, primarily reflecting increases in Medicaid and Medicare products, partially offset by declines in Commercial products.

Medicare Update

On April 6, 2020, the U.S. Centers for Medicare & Medicaid Services ("CMS") issued its final notice detailing final 2021 Medicare Advantage benchmark payment rates (the "Final Notice"). Overall the Company projects the benchmark rates in the Final Notice will increase funding for its Medicare Advantage business, excluding the impact of the HIF in 2020, by approximately 1.8% in 2021 compared to 2020.

On January 15, 2021, CMS issued its Final Notice detailing final 2022 Medicare Advantage benchmark payment rates. Final 2022 Medicare Advantage rates resulted in an increase in industry benchmark rates of approximately 4.1%.

The ACA ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star ratings." Plans must have a star rating of four or higher (out of five) to qualify for bonus payments. CMS released the Company's 2021 star ratings in October 2020. The Company's 2021 star ratings will be used to determine which of the Company's Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2022. Based on the Company's membership at December 31, 2020, 83% of the Company's Medicare Advantage members were in plans with 2021 star ratings of at least four stars, consistent with 83% of the Company's Medicare Advantage members being in plans with 2020 star ratings of at least four stars based on the Company's membership at December 31, 2019.

Corporate/Other Segment

The following table summarizes the Corporate/Other segment's performance for the respective periods:

				Change			
	Year Ended December 31,			2020 vs. 2019		2019 vs. 2018	
In millions, except percentages	**2020**	**2019**	**2018**	**$**	**%**	**$**	**%**
Revenues:							
Premiums	$ 63	$ 91	$ 4	$ (28)	(30.8)%	$ 87	2,175.0 %
Services	48	9	—	39	433.3 %	9	100.0 %
Net investment income	315	412	602	(97)	(23.5)%	(190)	(31.6)%
Total revenues	426	512	606	(86)	(16.8)%	(94)	(15.5)%
Benefit costs	221	285	22	(64)	(22.5)%	263	1,195.5 %
Operating expenses	1,846	1,710	1,389	136	8.0 %	321	23.1 %
Operating loss	(1,641)	(1,483)	(805)	(158)	(10.7)%	(678)	(84.2)%
Adjusted operating loss [1]	(1,306)	(1,000)	(856)	(306)	(30.6)%	(144)	(16.8)%

(1) See "Segment Analysis" above in this MD&A for a reconciliation of operating loss (GAAP measure) to adjusted operating loss for the Corporate/Other segment.

Commentary - 2020 compared to 2019

Revenues

- Revenues primarily relate to products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, that were acquired in the Aetna Acquisition. In 2018, revenues relate primarily to interest income on the proceeds from the financing of the Aetna Acquisition.
- Total revenues decreased $86 million in 2020 compared to 2019. The decrease was primarily driven by lower net investment income including an $80 million decrease in net realized capital gains in 2020 compared to 2019.

Operating expenses

- Operating expenses within the Corporate/Other segment consist of management and administrative expenses to support the Company's overall operations, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments, expenses associated with the Company's investments in its transformation and enterprise modernization programs and acquisition-related transaction and integration costs. Subsequent to the Aetna Acquisition Date, segment operating expenses also include operating costs to support the Company's large case pensions and long-term care insurance products.
- Operating expenses increased $136 million in 2020 compared to 2019. The increase was primarily driven by incremental operating expenses associated with the Company's investments in transformation and its COVID-19

pandemic response efforts, as well as increased charitable contributions in 2020. The increase was partially offset by a $148 million decrease in acquisition-related integration costs compared to the prior year.

Liquidity and Capital Resources

Cash Flows

The Company maintains a level of liquidity sufficient to allow it to meet its cash needs in the short-term. Over the long term, the Company manages its cash and capital structure to maximize shareholder return, maintain its financial condition and maintain flexibility for future strategic initiatives. The Company continuously assesses its regulatory capital requirements, working capital needs, debt and leverage levels, debt maturity schedule, capital expenditure requirements, dividend payouts, potential share repurchases and future investments or acquisitions. The Company believes its operating cash flows, commercial paper program, credit facilities, sale-leaseback program, as well as any potential future borrowings, will be sufficient to fund these future payments and long-term initiatives. As of December 31, 2020, the Company had approximately $7.9 billion in cash and cash equivalents, approximately $2.2 billion of which was held by the parent company or nonrestricted subsidiaries.

The COVID-19 pandemic has severely impacted global economic activity and during the first half of the year caused significant volatility and negative pressure in the capital markets. As a result of the uncertainty generated by COVID-19, on March 31, 2020, the Company issued $4.0 billion aggregate principal amount of unsecured senior notes to enhance its liquidity and strengthen its capital. As markets stabilized, in August 2020, the Company purchased $6.0 billion of its outstanding senior notes through cash tender offers, while issuing $4.0 billion aggregate principal amount of unsecured senior notes. In December 2020, the Company purchased $4.5 billion of its outstanding senior notes through cash tender offers, while issuing $2.0 billion aggregate principal amount of unsecured senior notes. The Company will continue to monitor the severity and duration of the pandemic and its impact on the U.S. and global economies, consumer behavior and health care utilization patterns and our businesses, results of operations, financial condition, and cash flows.

The net change in cash, cash equivalents and restricted cash for the years ended December 31, 2020, 2019 and 2018 was as follows:

				Change			
	Year Ended December 31,			2020 vs. 2019		2019 vs. 2018	
In millions	**2020**	**2019**	**2018**	**$**	**%**	**$**	**%**
Net cash provided by operating activities	$ 15,865	$ 12,848	$ 8,865	$ 3,017	23.5 %	$ 3,983	44.9 %
Net cash used in investing activities	(5,534)	(3,339)	(43,285)	(2,195)	65.7 %	39,946	92.3 %
Net cash provided by (used in) financing activities	(8,155)	(7,850)	36,819	(305)	3.9 %	(44,669)	(121.3)%
Effect of exchange rate changes on cash, cash equivalents and restricted cash	—	—	(4)	—	— %	4	100.0 %
Net increase in cash, cash equivalents and restricted cash	$ 2,176	$ 1,659	$ 2,395	$ 517	31.2 %	$ (736)	(30.7)%

Commentary - 2020 compared to 2019

- *Net cash provided by operating activities* increased by $3.0 billion in 2020 compared to 2019 due primarily to higher operating income in the Health Care Benefits segment and the deferral of approximately $670 million of certain payroll tax payments to future years, as permitted in response to the COVID-19 pandemic.
- *Net cash used in investing activities* increased by $2.2 billion in 2020 compared to 2019 primarily due to increased net purchases of investments and an increase in cash used for acquisitions, partially offset by $840 million in proceeds from the sale of the Workers' Compensation business. In addition, cash used in investing activities reflected the following activity:
    - Gross capital expenditures remained relatively consistent at approximately $2.4 billion and $2.5 billion in 2020 and 2019, respectively. During 2020, approximately 62% of the Company's total capital expenditures were for technology and other corporate initiatives, 30% were for store, fulfillment and support facilities expansion and improvements and 8% were for new store construction.

- *Net cash used in financing activities* increased slightly to $8.2 billion in 2020 compared to $7.9 billion in 2019. The increase in cash used in finance activities primarily related to an increase in net debt repaid during 2020 compared to 2019.

Included in net cash used in investing activities for the years ended December 31, 2020, 2019 and 2018 was the following store development activity: [1]

	2020	2019	2018
Total stores (beginning of year)	9,896	9,921	9,803
New and acquired stores [2]	156	102	145
Closed stores [2]	(90)	(127)	(27)
Total stores (end of year)	9,962	9,896	9,921
Relocated stores [2]	18	23	34

(1) Includes retail drugstores and pharmacies within retail chains, primarily in Target Corporation ("Target") stores.
(2) Relocated stores are not included in new and acquired stores or closed stores totals.

Short-term Borrowings

Commercial Paper and Back-up Credit Facilities
The Company did not have any commercial paper outstanding as of December 31, 2020 or 2019. In connection with its commercial paper program, the Company maintains a $1.0 billion 364-day unsecured back-up revolving credit facility, which expires on May 12, 2021, a $1.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 18, 2022, a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 17, 2023 and a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 16, 2024. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately 0.03%, regardless of usage. As of December 31, 2020 and 2019, there were no borrowings outstanding under any of the Company's back-up credit facilities.

Federal Home Loan Bank of Boston
Since the Aetna Acquisition Date, a subsidiary of the Company is a member of the Federal Home Loan Bank of Boston (the "FHLBB"). As a member, the subsidiary has the ability to obtain cash advances, subject to certain minimum collateral requirements. The maximum borrowing capacity available from the FHLBB as of December 31, 2020 was approximately $925 million. At both December 31, 2020 and 2019, there were no outstanding advances from the FHLBB.

Long-term Borrowings

2020 Notes
On December 16, 2020, the Company issued $750 million aggregate principal amount of 1.3% unsecured senior notes due August 21, 2027 and $1.25 billion aggregate principal amount of 1.875% unsecured senior notes due February 28, 2031 for total proceeds of approximately $1.99 billion, net of discounts and underwriting fees. The $750 million aggregate principal amount of 1.3% unsecured senior notes represent a further issuance of the Company's 1.3% unsecured senior notes due August 21, 2027 initially issued in an aggregate principal amount of $1.5 billion on August 21, 2020.

On August 21, 2020, the Company issued $1.5 billion aggregate principal amount of 1.3% unsecured senior notes due August 21, 2027, $1.25 billion aggregate principal amount of 1.75% unsecured senior notes due August 21, 2030 and $1.25 billion aggregate principal amount of 2.7% unsecured senior notes due August 21, 2040 (collectively, the "August 2020 Notes") for total proceeds of approximately $3.97 billion, net of discounts and underwriting fees.

On March 31, 2020, the Company issued $750 million aggregate principal amount of 3.625% unsecured senior notes due April 1, 2027, $1.5 billion aggregate principal amount of 3.75% unsecured senior notes due April 1, 2030, $1.0 billion aggregate principal amount of 4.125% unsecured senior notes due April 1, 2040 and $750 million aggregate principal amount of 4.25% unsecured senior notes due April 1, 2050 (collectively, the "March 2020 Notes") for total proceeds of approximately $3.95 billion, net of discounts and underwriting fees.

The net proceeds of these offerings were used for general corporate purposes, which may include working capital, capital expenditures, as well as the repurchase and/or repayment of indebtedness.

During March 2020, the Company entered into several interest rate swap transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of the March 2020 Notes. In connection with the

issuance of the March 2020 Notes, the Company terminated all outstanding cash flow hedges. The Company paid a net amount of $7 million to the hedge counterparties upon termination, which was recorded as a loss, net of tax, of $5 million in accumulated other comprehensive income and will be reclassified as interest expense over the life of the March 2020 Notes. See Note 13 ‘‘Other Comprehensive Income’’ included in Item 8 of this 10-K for additional information.

2019 Notes
On August 15, 2019, the Company issued $1.0 billion aggregate principal amount of 2.625% unsecured senior notes due August 15, 2024, $750 million aggregate principal amount of 3% unsecured senior notes due August 15, 2026 and $1.75 billion aggregate principal amount of 3.25% unsecured senior notes due August 15, 2029 (collectively, the “2019 Notes”) for total proceeds of approximately $3.46 billion, net of discounts and underwriting fees. The net proceeds of the 2019 Notes were used to repay certain of the Company’s outstanding debt.

Beginning in July 2019, the Company entered into several interest rate swap and treasury lock transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of the 2019 Notes. In connection with the issuance of the 2019 Notes, the Company terminated all outstanding cash flow hedges. The Company paid a net amount of $25 million to the hedge counterparties upon termination, which was recorded as a loss, net of tax, of $18 million in accumulated other comprehensive income and will be reclassified as interest expense over the life of the 2019 Notes. See Note 13 ‘‘Other Comprehensive Income’’ included in Item 8 of this 10-K for additional information.

Early Extinguishments of Debt
In December 2020, the Company purchased $4.5 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $113 million of its 4.0% senior notes due 2023, $1.4 billion of its 3.7% senior notes due 2023, $1.0 billion of its 4.1% senior notes due 2025 and $2.0 billion of its 4.3% senior notes due 2028. In connection with the purchase of such senior notes, the Company paid a premium of $619 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $45 million of unamortized deferred financing costs and incurred $10 million in fees, for a total loss on early extinguishment of debt of $674 million.

In August 2020, the Company purchased $6.0 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $723 million of its 4.0% senior notes due 2023, $2.3 billion of its 3.7% senior notes due 2023 and $3.0 billion of its 4.1% senior notes due 2025. In connection with the purchase of such senior notes, the Company paid a premium of $706 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $47 million of unamortized deferred financing costs and incurred $13 million in fees, for a total loss on early extinguishment of debt of $766 million.

In August 2019, the Company purchased $4.0 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $1.3 billion of its 3.125% senior notes due 2020, $723 million of its floating rate notes due 2020, $328 million of its 4.125% senior notes due 2021, $297 million of 4.125% senior notes due 2021 issued by Aetna, $413 million of 5.45% senior notes due 2021 issued by Coventry Health Care, Inc., a wholly-owned subsidiary of Aetna, and $962 million of its 3.35% senior notes due 2021. In connection with the purchase of such senior notes, the Company paid a premium of $76 million in excess of the aggregate principal amount of the senior notes that were purchased, incurred $8 million in fees and recognized a net gain of $5 million on the write-off of net unamortized deferred financing premiums, for a net loss on early extinguishment of debt of $79 million.

See Note 8 ‘‘Borrowings and Credit Agreements’’ and Note 12 ‘‘Shareholders’ Equity’’ included in Item 8 of this 10-K for additional information about debt issuances, debt repayments, share repurchases and dividend payments.

Derivative Financial Instruments

The Company uses derivative financial instruments in order to manage interest rate and foreign exchange risk and credit exposure. The Company’s use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps.

Debt Covenants

The Company's back-up revolving credit facilities, unsecured senior notes and unsecured floating rate notes (see Note 8 ''Borrowings and Credit Agreements'' included in Item 8 of this 10-K) contain customary restrictive financial and operating covenants. These covenants do not include an acceleration of the Company's debt maturities in the event of a downgrade in the

Company's credit ratings. The Company does not believe the restrictions contained in these covenants materially affect its financial or operating flexibility. As of December 31, 2020, the Company was in compliance with all of its debt covenants.

Debt Ratings

As of December 31, 2020, the Company's long-term debt was rated "Baa2" by Moody's Investors Service, Inc. ("Moody's") and "BBB" by Standard & Poor's Financial Services LLC ("S&P"), and its commercial paper program was rated "P-2" by Moody's and "A-2" by S&P. The outlook on the Company's long-term debt is "Stable" by S&P. In December 2020, Moody's changed the outlook on the Company's long-term debt from "Negative" to "Stable." In assessing the Company's credit strength, the Company believes that both Moody's and S&P considered, among other things, the Company's capital structure and financial policies as well as its consolidated balance sheet, its historical acquisition activity and other financial information. Although the Company currently believes its long-term debt ratings will remain investment grade, it cannot guarantee the future actions of Moody's and/or S&P. The Company's debt ratings have a direct impact on its future borrowing costs, access to capital markets and new store operating lease costs.

Share Repurchase Programs

During the years ended December 31, 2020, 2019 and 2018, the Company did not repurchase any shares of common stock. See Note 12 ''Shareholders' Equity'' included in Item 8 of this 10-K for additional information on the Company's share repurchase program.

Quarterly Cash Dividend

During 2020, 2019 and 2018, the quarterly cash dividend was $0.50 per share. CVS Health has paid cash dividends every quarter since becoming a public company and expects to maintain its quarterly dividend of $0.50 per share throughout 2021. Future dividends will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

Future Cash Requirements

The following table summarizes certain estimated future cash requirements under the Company's various contractual obligations at December 31, 2020, in total and disaggregated into current and long-term obligations. The table below does not include future payments of claims to health care providers or pharmacies because certain terms of these payments are not determinable at December 31, 2020 (for example, the timing and volume of future services provided under fee-for-service arrangements and future membership levels for capitated arrangements).

In millions	**Total**	**Current**	**Long-Term**
Operating lease liabilities [1]	$ 27,142	$ 2,688	$ 24,454
Finance lease liabilities [1]	1,812	100	1,712
Contractual lease obligations with Target [2]	2,332	—	2,332
Long-term debt [3]	64,235	5,405	58,830
Interest payments on long-term debt [3]	34,565	2,409	32,156
Other long-term liabilities on the consolidated balance sheets [4]			
Future policy benefits [5]	5,983	462	5,521
Unpaid claims [5]	2,018	532	1,486
Policyholders' funds [5] [6]	1,870	1,374	496
Total	$ 139,957	$ 12,970	$ 126,987

(1) Refer to Note 6 ''Leases'' included in Item 8 of this 10-K for additional information regarding the maturity of lease liabilities under operating and finance leases.

(2) The Company leases pharmacy and clinic space from Target. See Note 6 ''Leases'' included in Item 8 of this 10-K for additional information regarding the lease arrangements with Target. Amounts related to such operating and finance leases are reflected within the operating lease

liabilities and finance lease liabilities in the table above. Pharmacy lease amounts due in excess of the remaining estimated economic life of the buildings are reflected in the table above assuming equivalent stores continue to operate through the term of the arrangements.

(3) Refer to Note 8 ‘‘Borrowings and Credit Agreements” included in Item 8 of this 10-K for additional information regarding the maturities of debt principal. Interest payments on long-term debt are calculated using outstanding balances and interest rates in effect on December 31, 2020.

(4) Payments of other long-term liabilities exclude Separate Accounts liabilities of approximately $4.9 billion because these liabilities are supported by assets that are legally segregated and are not subject to claims that arise out of the Company’s business.

(5) Total payments of future policy benefits, unpaid claims and policyholders' funds include $763 million, $2.0 billion and $210 million, respectively, of reserves for contracts subject to reinsurance. The Company expects the assuming reinsurance carrier to fund these obligations and has reflected these amounts as reinsurance recoverable assets on the consolidated balance sheets.

(6) Customer funds associated with group life and health contracts of approximately $2.9 billion have been excluded from the table above because such funds may be used primarily at the customer's discretion to offset future premiums and/or for refunds, and the timing of the related cash flows cannot be determined. Additionally, net unrealized capital gains on debt securities supporting experience-rated products of $135 million, before tax, have been excluded from the table above.

Restrictions on Certain Payments

In addition to general state law restrictions on payments of dividends and other distributions to stockholders applicable to all corporations, health maintenance organizations ("HMOs") and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity (referred to as surplus) and restrict the amount of dividends and other distributions that may be paid to their equity holders. These regulations are not directly applicable to CVS Health as a holding company, since CVS Health is not an HMO or an insurance company. In addition, in connection with the Aetna Acquisition, the Company made certain undertakings that require prior regulatory approval of dividends by certain of its HMOs and insurance companies. The additional regulations and undertakings applicable to the Company's HMO and insurance company subsidiaries are not expected to affect the Company's ability to service the Company's debt, meet other financing obligations or pay dividends, or the ability of any of the Company's subsidiaries to service their debt or other financing obligations. Under applicable regulatory requirements and undertakings, at December 31, 2020, the maximum amount of dividends that may be paid by the Company's insurance and HMO subsidiaries without prior approval by regulatory authorities was $2.9 billion in the aggregate.

The Company maintains capital levels in its operating subsidiaries at or above targeted and/or required capital levels and dividends amounts in excess of these levels to meet liquidity requirements, including the payment of interest on debt and stockholder dividends. In addition, at the Company's discretion, it uses these funds for other purposes such as funding share and debt repurchase programs, investments in new businesses and other purposes considered advisable.

At December 31, 2020 and 2019, the Company held investments of $524 million and $537 million, respectively, that are not accounted for as Separate Accounts assets but are legally segregated and are not subject to claims that arise out of the Company's business. See Note 3 ''Investments'' included in Item 8 of this 10-K for additional information on investments related to the 2012 conversion of an existing group annuity contract from a participating to a non-participating contract.

Solvency Regulation

The National Association of Insurance Commissioners (the "NAIC") utilizes risk-based capital ("RBC") standards for insurance companies that are designed to identify weakly-capitalized companies by comparing each company's adjusted surplus to its required surplus (the "RBC Ratio"). The RBC Ratio is designed to reflect the risk profile of insurance companies. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring an insurer to submit a comprehensive financial plan for increasing its RBC to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2020, the RBC Ratio of each of the Company's primary insurance subsidiaries was above the level that would require regulatory action. The RBC framework described above for insurers has been extended by the NAIC to health organizations, including HMOs. Although not all states had adopted these rules at December 31, 2020, at that date, each of the Company's active HMOs had a surplus that exceeded either the applicable state net worth requirements or, where adopted, the levels that would require regulatory action under the NAIC's RBC rules. External rating agencies use their own capital models and/or RBC standards when they determine a company's rating.

Critical Accounting Policies

The Company prepares the consolidated financial statements in conformity with generally accepted accounting principles, which require management to make certain estimates and apply judgment. Estimates and judgments are based on historical experience, current trends and other factors that management believes to be important at the time the consolidated financial statements are prepared. On a regular basis, the Company reviews its accounting policies and how they are applied and disclosed in the consolidated financial statements. While the Company believes the historical experience, current trends and other factors considered by management support the preparation of the consolidated financial statements in conformity with generally accepted accounting principles, actual results could differ from estimates, and such differences could be material.

Significant accounting policies are discussed in Note 1 ‘‘Significant Accounting Policies’’ included in Item 8 of this 10-K. Management believes the following accounting policies include a higher degree of judgment and/or complexity and, thus, are considered to be critical accounting policies. The Company has discussed the development and selection of these critical accounting policies with the Audit Committee of the Board (the “Audit Committee”), and the Audit Committee has reviewed the disclosures relating to them.

Revenue Recognition

Pharmacy Services Segment
The Pharmacy Services segment sells prescription drugs directly through its mail service dispensing pharmacies and indirectly through the Company’s retail pharmacy network. The Company’s pharmacy benefit arrangements are accounted for in a manner consistent with a master supply arrangement as there are no contractual minimum volumes and each prescription is considered a separate purchasing decision and distinct performance obligation transferred at a point in time. PBM services performed in connection with each prescription claim are considered part of a single performance obligation which culminates in the dispensing of prescription drugs.

The Company recognizes revenue using the gross method at the contract price negotiated with its clients when the Company has concluded it controls the prescription drug before it is transferred to the client plan members. The Company controls prescriptions dispensed indirectly through its retail pharmacy network because it has separate contractual arrangements with those pharmacies, has discretion in setting the price for the transaction and assumes primary responsibility for fulfilling the promise to provide prescription drugs to its client plan members while also performing the related PBM services.

Revenues include (i) the portion of the price the client pays directly to the Company, net of any discounts earned on brand name drugs or other discounts and refunds paid back to the client (see “Drug Discounts” and “Guarantees” below), (ii) the price paid to the Company by client plan members for mail order prescriptions and the price paid to retail network pharmacies by client plan members for retail prescriptions (“retail co-payments”), and (iii) claims based administrative fees for retail pharmacy network contracts. Sales taxes are not included in revenues.

The Company recognizes revenue when control of the prescription drugs is transferred to customers, in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those prescription drugs. The Company has established the following revenue recognition policies for the Pharmacy Services segment:

- Revenues generated from prescription drugs sold by mail service dispensing pharmacies are recognized when the prescription drug is delivered to the client plan member. At the time of delivery, the Company has performed substantially all of its performance obligations under its client contracts and does not experience a significant level of returns or reshipments.
- Revenues generated from prescription drugs sold by third party pharmacies in the Company’s retail pharmacy network and associated administrative fees are recognized at the Company’s point-of-sale, which is when the claim is adjudicated by the Company’s online claims processing system and the Company has transferred control of the prescription drug and performed all of its performance obligations.

For contracts under which the Company acts as an agent or does not control the prescription drugs prior to transfer to the client plan member, revenue is recognized using the net method.

<u>Drug Discounts</u>

The Company records revenue net of manufacturers' rebates earned by its clients based on their plan members' utilization of brand-name formulary drugs. The Company estimates these rebates at period-end based on actual and estimated claims data and its estimates of the manufacturers' rebates earned by its clients. The estimates are based on the best available data at period-end

and recent history for the various factors that can affect the amount of rebates due to the client. The Company adjusts its rebates payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. Any cumulative effect of these adjustments is recorded against revenues at the time it is identified. Adjustments generally result from contract changes with clients or manufacturers that have retroactive rebate adjustments, differences between the estimated and actual product mix subject to rebates, or whether the brand name drug was included in the applicable formulary. The effect of adjustments between estimated and actual manufacturers' rebate amounts has not been material to the Company's operating results or financial condition.

Guarantees

The Company also adjusts revenues for refunds owed to clients resulting from pricing guarantees and performance against defined service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Retail/LTC Segment

Retail Pharmacy

The Company's retail drugstores recognize revenue at the time the customer takes possession of the merchandise. For pharmacy sales, each prescription claim is its own arrangement with the customer and is a performance obligation, separate and distinct from other prescription claims under other retail network arrangements. Revenues are adjusted for refunds owed to third party payers resulting from pricing guarantees and performance against defined value-based service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Revenue from Company gift cards purchased by customers is deferred as a contract liability until goods or services are transferred. Any amounts not expected to be redeemed by customers (i.e., breakage) are recognized based on historical redemption patterns.

Customer returns are not material to the Company's operating results or financial condition. Sales taxes are not included in revenues.

Loyalty and Other Programs

The Company's customer loyalty program, ExtraCare®, consists of two components, ExtraSavings™ and ExtraBucks® Rewards. ExtraSavings are coupons that are recorded as a reduction of revenue when redeemed as the Company concluded that they do not represent a promise to the customer to deliver additional goods or services at the time of issuance because they are not tied to a specific transaction or spending level.

ExtraBucks Rewards are accumulated by customers based on their historical spending levels. Thus, the Company has determined that there is an additional performance obligation to those customers at the time of the initial transaction. The Company allocates the transaction price to the initial transaction and the ExtraBucks Rewards transaction based upon the relative standalone selling price, which considers historical redemption patterns for the rewards. Revenue allocated to ExtraBucks Rewards is recognized as those rewards are redeemed. At the end of each period, unredeemed ExtraBucks Rewards are reflected as a contract liability.

The Company also offers a subscription-based membership program, CarePass®, under which members are entitled to a suite of benefits delivered over the course of the subscription period, as well as a promotional reward that can be redeemed for future goods and services. Subscriptions are paid for on a monthly or annual basis at the time of or in advance of the Company delivering the goods and services. Revenue from these arrangements is recognized as the performance obligations are satisfied.

Long-term Care

Revenue is recognized when control of the promised goods or services is transferred to customers in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those goods or services. Each prescription claim represents a separate performance obligation of the Company, separate and distinct from other prescription claims under customer arrangements. A significant portion of Long-term Care revenue from sales of pharmaceutical and medical products is reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. The Company monitors its revenues and receivables from these reimbursement sources, as

well as long-term care facilities and other third party insurance payors, and reduces revenue at the revenue recognition date to properly account for the variable consideration due to anticipated

differences between billed and reimbursed amounts. Accordingly, the total revenues and receivables reported in the Company's consolidated financial statements are recorded at the amount expected to be ultimately received from these payors.

Patient co-payments associated with Medicare Part D, certain state Medicaid programs, Medicare Part B and certain third party payors typically are not collected at the time products are delivered or services are rendered, but are billed to the individuals as part of normal billing procedures and subject to normal accounts receivable collections procedures.

Walk-In Medical Clinics

For services provided by the Company's walk-in medical clinics, revenue recognition occurs for completed services provided to patients, with adjustments taken for third party payor contractual obligations and patient direct bill historical collection rates.

Health Care Benefits Segment

Health Care Benefits revenue is principally derived from insurance premiums and fees billed to customers. Revenue is recognized based on customer billings, which reflect contracted rates per employee and the number of covered employees recorded in the Company's records at the time the billings are prepared. Billings are generally sent monthly for coverage during the following month.

The Company's billings may be subsequently adjusted to reflect enrollment changes due to member terminations or other factors. These adjustments are known as retroactivity adjustments. In each period, the Company estimates the amount of future retroactivity and adjusts the recorded revenue accordingly. As information regarding actual retroactivity amounts becomes known, the Company refines its estimates and records any required adjustments to revenues in the period in which they arise. A significant difference in the actual level of retroactivity compared to estimated levels would have a significant effect on the Company's operating results.

Premium Revenue

Premiums are recognized as revenue in the month in which the enrollee is entitled to receive health care services. Premiums are reported net of an allowance for estimated terminations and uncollectible amounts. Additionally, premium revenue subject to the MLR rebate requirements of the ACA is recorded net of the estimated minimum MLR rebates for the current calendar year. Premiums related to unexpired contractual coverage periods (unearned premiums) are reported as other insurance liabilities on the consolidated balance sheets and recognized as revenue when earned.

Some of the Company's contracts allow for premiums to be adjusted to reflect actual experience or the relative health status of Insured members. Such adjustments are reasonably estimable at the outset of the contract, and adjustments to those estimates are made based on actual experience of the customer emerging under the contract and the terms of the underlying contract.

Services Revenue

Services revenue relates to contracts that can include various combinations of services or series of services which generally are capable of being distinct and accounted for as separate performance obligations. The Health Care Benefits segment's services revenue primarily consists of ASC fees received in exchange for performing certain claim processing and member services for ASC members. ASC fee revenue is recognized over the period the service is provided. Some of the Company's administrative services contracts include guarantees with respect to certain functions, such as customer service response time, claim processing accuracy and claim processing turnaround time, as well as certain guarantees that a plan sponsor's benefit claim experience will fall within a certain range. With any of these guarantees, the Company is financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk typically is limited to a percentage of the fees otherwise payable to the Company by the customer involved. Each period the Company estimates its obligations under the terms of these guarantees and records its estimate as an offset to services revenues.

Accounting for Medicare Part D

Revenues include insurance premiums earned by the Company's PDPs, which are determined based on the PDP's annual bid and related contractual arrangements with CMS. The insurance premiums include a beneficiary premium, which is the responsibility of the PDP member, and can be subsidized by CMS in the case of low-income members,

and a direct premium paid by CMS. Premiums collected in advance are initially recorded within other insurance liabilities and are then recognized ratably as revenue over the period in which members are entitled to receive benefits.

Revenues also include a risk-sharing feature of the Medicare Part D program design referred to as the risk corridor. The Company estimates variable consideration in the form of amounts payable to, or receivable from, CMS under the risk corridor, and adjusts revenue based on calculations of additional subsidies to be received from or owed to CMS at the end of the reporting year.

In addition to Medicare Part D premiums, the Company receives additional payments each month from CMS related to catastrophic reinsurance, low-income cost-sharing subsidies and coverage gap benefits. If the subsidies received differ from the amounts earned from actual prescriptions transferred, the difference is recorded in either accounts receivable, net or accrued expenses.

Impairments of Debt Securities

The Company regularly reviews its debt securities to determine whether a decline in fair value below the cost basis or carrying value has occurred. If a debt security is in an unrealized loss position and the Company has the intent to sell the security, or it is more likely than not that the Company will have to sell the security before recovery of its amortized cost basis, the amortized cost basis of the security is written down to its fair value and the difference is recognized in net income. If a debt security is in an unrealized loss position and the Company does not have the intent to sell and it is more likely than not that the Company will not have to sell such security before recovery of its amortized cost basis, the Company bifurcates the impairment into credit-related and non-credit related components. The amount of the credit-related component is recorded as an allowance for credit losses and recognized in net income, and the amount of the non-credit related component is included in other comprehensive income. The Company analyzes all facts and circumstances believed to be relevant for each investment when performing this analysis, in accordance with applicable accounting guidance.

In evaluating whether a credit related loss exists, the Company considers a variety of factors including: the extent to which the fair value is less than the amortized cost basis; adverse conditions specifically related to the issuer of a security, an industry or geographic area; the payment structure of the security; the failure of the issuer of the security to make scheduled interest or principle payments; and any changes to the rating of the security by a rating agency.

During the year ended December 31, 2020, the Company recorded yield-related impairment losses on debt securities of $49 million. During the year ended December 31, 2020, the Company did not record credit-related impairment losses on debt securities. During the year ended December 31, 2019, the Company recorded other-than-temporary impairment ("OTTI") losses on debt securities of $24 million. There were no material OTTI losses on debt securities for the year ended December 31, 2018.

The risks inherent in assessing the impairment of a debt security include the risk that market factors may differ from projections and the risk that facts and circumstances factored into the Company's assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods are among the factors that may result in a current period decision to sell debt securities that were not impaired in prior reporting periods.

Vendor Allowances and Purchase Discounts

Vendor and manufacturer receivables were $9.8 billion and $7.9 billion as of December 31, 2020 and 2019, respectively, the majority of which relate to purchase discounts and vendor allowances as described below.

Pharmacy Services Segment
The Pharmacy Services segment receives purchase discounts on products purchased. Contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for the Pharmacy Services segment to receive purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These rebates are recognized when prescriptions are dispensed and are generally calculated and billed to manufacturers within 30 days of the end of each completed quarter. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material to the Company's operating results or financial condition. The Company accounts for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. The Pharmacy Services segment also receives additional discounts under its wholesaler contracts if it exceeds contractually defined purchase volumes. In addition, the Pharmacy Services segment receives fees from pharmaceutical manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of cost of products sold.

Retail/LTC Segment
Vendor allowances received by the Retail/LTC segment reduce the carrying cost of inventory and are recognized in cost of products sold when the related inventory is sold, unless they are specifically identified as a reimbursement of incremental costs for promotional programs and/or other services provided. Amounts that are directly linked to advertising commitments are

recognized as a reduction of advertising expense (included in operating expenses) when the related advertising commitment is satisfied. Any such allowances received in excess of the actual cost incurred also reduce the carrying cost of inventory. The total value of any upfront payments received from vendors that are linked to purchase commitments is initially deferred. The deferred amounts are then amortized to reduce cost of products sold over the life of the contract based upon purchase volume. The total value of any upfront payments received from vendors that are not linked to purchase commitments is also initially deferred. The deferred amounts are then amortized to reduce cost of products sold on a straight-line basis over the life of the related contract.

The Company establishes a receivable for vendor income that is earned but not yet received based on historical trends and data. The majority of vendor receivables are collected within the following fiscal quarter. Historically, adjustments to the Company's vendor receivables resulting from the reconciliation of receivables recognized to the amounts collected have not been material to the Company's operating results or financial condition.

There have not been any material changes in the way the Company accounts for vendor allowances or purchase discounts during the past three years.

Inventory

Inventories are valued at the lower of cost or net realizable value using the weighted average cost method.

The value of ending inventory is reduced for estimated inventory losses that have occurred during the interim period between physical inventory counts. Physical inventory counts are taken on a regular basis in each retail store and LTC pharmacy, and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the consolidated financial statements are properly stated. The Company's accounting for inventory contains uncertainty since management must use judgment to estimate the inventory losses that have occurred during the interim period between physical inventory counts. When estimating these losses, a number of factors are considered which include historical physical inventory results on a location-by-location basis and current physical inventory loss trends.

The total reserve for estimated inventory losses covered by this critical accounting policy was $369 million and $401 million as of December 31, 2020 and 2019, respectively. Although management believes there is sufficient current and historical information available to record reasonable estimates for estimated inventory losses, it is possible that actual results could differ. In order to help investors assess the aggregate risk, if any, associated with the inventory-related uncertainties discussed above, a ten percent (10%) pre-tax change in estimated inventory losses, which is a reasonably likely change, would increase or decrease the total reserve for estimated inventory losses by approximately $37 million as of December 31, 2020.

Although management believes that the estimates discussed above are reasonable and the related calculations conform to generally accepted accounting principles, actual results could differ from such estimates, and such differences could be material.

Right-of-Use Assets and Lease Liabilities

The Company determines if an arrangement contains a lease at the inception of a contract. Right-of-use assets represent the Company's right to use an underlying asset for the lease term and lease liabilities represent the Company's obligation to make lease payments arising from the lease. Right-of-use assets and lease liabilities are recognized at the commencement date of the lease, renewal date of the lease or significant remodeling of the lease space based on the present value of the remaining future minimum lease payments. As the interest rate implicit in the Company's leases is not readily determinable, the Company utilizes its incremental borrowing rate, determined by class of underlying asset, to discount the lease payments. The operating lease right-of-use assets also include lease payments made before commencement and are reduced by lease incentives.

The Company's real estate leases typically contain options that permit renewals for additional periods of up to five years each. For real estate leases, the options to extend are not considered reasonably certain at lease commencement because the Company reevaluates each lease on a regular basis to consider the economic and strategic incentives of exercising the renewal options and regularly opens or closes stores to align with its operating strategy. Generally, the renewal option periods are not included within the lease term and the associated payments are not included in the

measurement of the right-of-use asset and lease liability. Similarly, renewal options are not included in the lease term for non-real estate leases because they are not considered reasonably certain of being exercised at lease commencement. Leases with an initial term of 12 months or less are not recorded on the balance sheets, and lease expense is recognized on a straight-line basis over the term of the short-term lease.

For real estate leases, the Company accounts for lease components and nonlease components as a single lease component. Certain real estate leases require additional payments based on sales volume, as well as reimbursement for real estate taxes, common area maintenance and insurance, which are expensed as incurred as variable lease costs. Other real estate leases contain one fixed lease payment that includes real estate taxes, common area maintenance and insurance. These fixed payments are considered part of the lease payment and included in the right-of-use assets and lease liabilities.

Long-Lived Asset Impairment

Recoverability of Definite-Lived Assets
The Company evaluates the recoverability of long-lived assets, excluding goodwill and indefinite-lived intangible assets, which are tested for impairment using separate tests described below, whenever events or changes in circumstances indicate that the carrying value of such an asset may not be recoverable. The Company groups and evaluates these long-lived assets for impairment at the lowest level at which individual cash flows can be identified. If indicators of impairment are present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted and without interest charges). If the estimated future cash flows used in this analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group's estimated future cash flows (discounted and with interest charges). If required, an impairment loss is recorded for the portion of the asset group's carrying value that exceeds the asset group's estimated future cash flows (discounted and with interest charges).

The long-lived asset impairment loss calculation contains uncertainty since management must use judgment to estimate each asset group's future sales, profitability and cash flows. When preparing these estimates, the Company considers historical results and current operating trends and consolidated sales, profitability and cash flow results and forecasts. These estimates can be affected by a number of factors including general economic and regulatory conditions, efforts of third party organizations to reduce their prescription drug costs and/or increased member co-payments, the continued efforts of competitors to gain market share and consumer spending patterns.

There were no material impairment charges recognized on long-lived assets in the year ended December 31, 2020. During the year ended December 31, 2019, the Company recorded store rationalization charges of $231 million, primarily related to operating lease right-of-use asset impairment charges. During the year ended December 31, 2018, the Company recognized a $43 million long-lived asset impairment charge, primarily related to the impairment of property and equipment.

Recoverability of Goodwill
Goodwill represents the excess of amounts paid for acquisitions over the fair value of the net identifiable assets acquired. Goodwill is subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable. Goodwill is tested for impairment on a reporting unit basis. The impairment test is performed by comparing the reporting unit's fair value with its net book value (or carrying amount), including goodwill. The fair value of the reporting units is estimated using a combination of a discounted cash flow method and a market multiple method. If the net book value (carrying amount) of the reporting unit exceeds its fair value, the reporting unit's goodwill is considered to be impaired, and an impairment is recognized in an amount equal to the excess.

The determination of the fair value of the reporting units requires the Company to make significant assumptions and estimates. These assumptions and estimates primarily include the selection of appropriate peer group companies; control premiums and valuation multiples appropriate for acquisitions in the industries in which the Company competes; discount rates; terminal growth rates; and forecasts of revenue, operating income, depreciation and amortization, income taxes, capital expenditures and future working capital requirements. When determining these assumptions and preparing these estimates, the Company considers each reporting unit's historical results and current operating trends; consolidated revenues, profitability and cash flow results and forecasts; and industry trends. The Company's estimates can be affected by a number of factors, including general economic and regulatory conditions; the risk-free interest rate environment; the Company's market capitalization; efforts of customers and payers to reduce costs, including their prescription drug costs, and/or increase member co-payments; the continued efforts of competitors to gain market share, consumer spending patterns and the Company's ability to achieve its revenue growth projections and execute on its cost reduction initiatives.

2020 Goodwill Impairment Test

During the third quarter of 2020, the Company performed its required annual impairment test of goodwill. The results of this impairment test indicated that there was no impairment of goodwill as of the testing date. The goodwill impairment test resulted in the fair values of all of the Company's reporting units exceeding their carrying values by significant margins, with the

exception of the Commercial Business and LTC reporting units, which exceeded their carrying values by approximately 6% and 12%, respectively.

In connection with the Aetna Acquisition in November 2018, the Company added the Health Care Benefits segment which included the Commercial Business reporting unit. The transaction was accounted for using the acquisition method of accounting which requires, among other things, the assets acquired and liabilities assumed to be recognized at their fair values at the date of acquisition. As a result, at the time of the acquisition the fair value of the Commercial Business reporting unit was equal to its carrying value.

The Company has experienced declines in its Commercial Insured medical membership subsequent to the closing date of the Aetna Acquisition and may continue to do so for a number of reasons, including as a result of the competitive Commercial business environment. In addition, COVID-19 has had and may continue to have an adverse impact on medical membership in the Commercial business due to reductions in workforce at existing customers (including due to business failures) as well as reduced willingness to change benefit providers by prospective customers. The Company's fair value estimate is sensitive to significant assumptions including changes in medical membership, revenue growth rate, operating income and the discount rate. Although the Company believes the financial projections used to determine the fair value of the Commercial Business reporting unit in the third quarter of 2020 were reasonable and achievable, the challenges described above may affect the Company's ability to increase medical membership or operating income in the Commercial Business reporting unit at the rate estimated when such goodwill impairment test was performed and may continue to do so. As of December 31, 2020, the goodwill balance in the Commercial Business reporting unit was $26.5 billion.

The LTC reporting unit continues to experience industry-wide challenges that have impacted management's ability to grow the business at the rate that was originally estimated when the Company acquired Omnicare in 2015. Those challenges included lower client retention rates, lower occupancy rates in skilled nursing facilities, the deteriorating financial health of numerous skilled nursing facility customers which resulted in a number of customer bankruptcies in 2018, and continued facility reimbursement pressures. COVID-19 has also had an adverse impact on the financial health of the Company's long-term care facility customers due to declines in occupancy rates and increased operating expenses. A number of these customers have relied on supplemental liquidity sources such as grants and advance Medicare payments under programs expanded or created under the CARES Act to maintain adequate liquidity during the COVID-19 pandemic and may require additional sources of liquidity throughout the duration of the COVID-19 pandemic.

Although the Company believes the financial projections used to determine the fair value of the LTC reporting unit in the third quarter of 2020 were reasonable and achievable, the LTC reporting unit has faced challenges that affect the Company's ability to grow the LTC reporting unit's business at the rate estimated when such goodwill impairment test was performed and may continue to do so. These challenges and some of the key assumptions included in the Company's financial projections to determine the estimated fair value of the LTC reporting unit include client retention rates; occupancy rates in skilled nursing facilities; the financial health of skilled nursing facility customers; facility reimbursement pressures; the Company's ability to extract cost savings from labor productivity and other initiatives; the geographies impacted and the severity and duration of COVID-19; COVID-19's impact on health care utilization patterns; and the timing, scope and impact of stimulus legislation as well as other federal, state and local governmental responses to COVID-19. The fair value of the LTC reporting unit also is dependent on market multiples of peer group companies and the risk-free interest rate environment, which impacts the discount rate used in the discounted cash flow valuation method. If the LTC reporting unit does not achieve its forecasts, it is reasonably possible in the near term that the goodwill of the LTC reporting unit could be deemed to be impaired by a material amount. As of December 31, 2020, the goodwill balance in the LTC reporting unit was $431 million.

The COVID-19 pandemic severely impacted global economic activity in 2020, including the businesses of some of the Company's customers, and during the first half of the year caused significant volatility and negative pressure in the capital markets. In addition to adversely affecting the Company's businesses, which may have a material adverse impact on the Company's profitability and cash flows, these developments may adversely affect the timing and collectability of payments to the Company from customers, clients, government payers and members as a result of the impact of COVID-19 on them. For further information regarding the potential adverse impact of COVID-19 on the Company, please see "Risk Factors" included in Item 1A of this report. The COVID-19 pandemic continues to evolve. We believe COVID-19's impact on our businesses, operating results, cash flows and/or financial condition primarily will be driven by the geographies impacted and the severity and duration of the pandemic; the pandemic's

impact on the U.S. and global economies and consumer behavior and health care utilization patterns; and the timing, scope and impact of stimulus legislation as well as other federal, state and local governmental responses to the pandemic. Those primary drivers are beyond our knowledge and control. As a result, the impact COVID-19 will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be adverse and material. COVID-19 also may result in legal and regulatory proceedings, investigations and claims against

us. If the Company's businesses, results of operations, financial condition and/or cash flows are materially adversely affected, the goodwill of the LTC and Commercial Business reporting units could be deemed to be impaired by a material amount.

2019 Goodwill Impairment Test

During the third quarter of 2019, the Company performed its required annual impairment test of goodwill. The results of this impairment test indicated that there was no impairment of goodwill as of the testing date. The goodwill impairment test resulted in the fair values of all of the Company's reporting units exceeding their carrying values by significant margins, with the exception of the Commercial Business and LTC reporting units, which exceeded their carrying values by approximately 4% and 9%, respectively.

2018 Goodwill Impairment Tests

As discussed in Note 5 ''Goodwill and Other Intangibles'' included in Item 8 of this 10-K, during 2018, the LTC reporting unit experienced industry-wide challenges that impacted management's ability to grow the business at the rate that was originally estimated when the Company acquired Omnicare and when the 2017 annual goodwill impairment test was performed. Those challenges include lower client retention rates, lower occupancy rates in skilled nursing facilities, the deteriorating financial health of numerous skilled nursing facility customers which resulted in a number of customer bankruptcies in 2018, and continued facility reimbursement pressures. Following the update of its current and long-term forecast, in June 2018, management determined that there were indicators that the LTC reporting unit's goodwill may be impaired and, accordingly, management performed an interim goodwill impairment test as of June 30, 2018. The results of that interim impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in a $3.9 billion pre-tax goodwill impairment charge in the second quarter of 2018.

During the third quarter of 2018, the Company performed its required annual impairment tests of goodwill and concluded there was no impairment of goodwill. The goodwill impairment tests showed that the fair values of the Pharmacy Services and Retail Pharmacy reporting units exceeded their carrying values by significant margins and the fair value of the LTC reporting unit exceeded its carrying value by approximately 2%.

During the fourth quarter of 2018, the LTC reporting unit missed its forecast primarily due to operational issues and customer liquidity issues, including one significant customer bankruptcy. Additionally, LTC management submitted updated projected financial results which showed significant additional deterioration primarily due to continued industry and operational challenges, which also caused management to make further updates to its long-term forecast beyond 2019. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be further impaired and, accordingly, management performed an interim goodwill impairment test during the fourth quarter of 2018. The results of that interim impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in an additional $2.2 billion pre-tax goodwill impairment charge in the fourth quarter of 2018.

In 2018, the fair value of the LTC reporting unit was determined using a combination of a discounted cash flow method and a market multiple method. In addition to the lower financial projections, changes in risk-free interest rates and lower market multiples of peer group companies also contributed to the amount of the 2018 goodwill impairment charges.

Recoverability of Indefinite-Lived Intangible Assets

Indefinite-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that their carrying value may not be recoverable. Indefinite-lived intangible assets are tested by comparing the estimated fair value of the asset to its carrying value. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized, and the asset is written down to its estimated fair value.

The indefinite-lived intangible asset impairment loss calculation contains uncertainty since management must use judgment to estimate fair value based on the assumption that, in lieu of ownership of an intangible asset, the Company would be willing to pay a royalty in order to utilize the benefits of the asset. Fair value is estimated by discounting the hypothetical royalty payments to their present value over the estimated economic life of the asset. These estimates can be affected by a number of factors including general economic conditions, availability of market information and the profitability of the Company. There were no impairment losses recognized on indefinite-lived intangible assets in any of the years ended December 31, 2020, 2019 or 2018.

Health Care Costs Payable

At December 31, 2020 and 2019, 77% and 73% respectively, of health care costs payable are estimates of the ultimate cost of (i) services rendered to the Company's Insured members but not yet reported to the Company and (ii) claims which have been

reported to the Company but not yet paid (collectively, “IBNR”). Health care costs payable also include an estimate of the cost of services that will continue to be rendered after the financial statement date if the Company is obligated to pay for such services in accordance with contractual or regulatory requirements. The remainder of health care costs payable is primarily comprised of pharmacy and capitation payables, other amounts due to providers pursuant to risk sharing agreements and accruals for state assessments. The Company develops its estimate of IBNR using actuarial principles and assumptions that consider numerous factors. See Note 1 ‘‘Significant Accounting Policies’’ included in Item 8 of this 10-K for additional information on the Company’s reserving methodology.

During 2020 and 2019, the Company observed an increase in completion factors relative to those assumed at the prior year end. After considering the claims paid in 2020 and 2019 with dates of service prior to the fourth quarter of the previous year, the Company observed assumed incurred claim weighted average completion factors that were 4 and 27 basis points higher, respectively, than previously estimated, resulting in a decrease of $35 million and $240 million in 2020 and 2019, respectively, in health care costs payable that related to the prior year. The Company has considered the pattern of changes in its completion factors when determining the completion factors used in its estimates of IBNR as of December 31, 2020. However, based on historical claim experience, it is reasonably possible that the Company’s estimated weighted average completion factors may vary by plus or minus 11 basis points from the Company’s assumed rates, which could impact health care costs payable by approximately plus or minus $140 million pretax.

Also during 2020 and 2019, the Company observed that health care costs for claims with claim incurred dates of three months or less before the financial statement date were lower than previously estimated. Specifically, after considering the claims paid in 2020 and 2019 with claim incurred dates for the fourth quarter of the previous year, the Company observed health care costs that were 4.0% and 3.2% lower, respectively, for each fourth quarter than previously estimated, resulting in a reduction of $394 million and $284 million in 2020 and 2019, respectively, in health care costs payable that related to prior year.

Management considers historical health care cost trend rates together with its knowledge of recent events that may impact current trends when developing estimates of current health care cost trend rates. When establishing reserves as of December 31, 2020, the Company increased its assumed health care cost trend rates for the most recent three months by 9.6% from health care cost trend rates recently observed. Assumed health care cost trend rates during the fourth quarter of 2020 are elevated compared to historical levels due to the impact of COVID-19 pandemic on utilization during 2020. Specifically, beginning in mid-March, the health system experienced a significant reduction in utilization that is discretionary and the cancellation of elective medical procedures. Utilization remained below historical levels through April, began to recover in May and June and reached more normal levels in the third and fourth quarters, with select geographies impacted by COVID-19 waves. Based on historical claim experience, it is reasonably possible that the Company’s estimated health care cost trend rates may vary by plus or minus 3.5% from the assumed rates, which could impact health care costs payable by plus or minus $404 million pretax.

Income Taxes

The Company accounts for income taxes using the asset and liability method. Deferred tax assets and liabilities are established for any temporary differences between financial and tax reporting bases and are adjusted as needed to reflect changes in the enacted tax rates expected to be in effect when the temporary differences reverse. Such adjustments are recorded in the period in which changes in tax laws are enacted, regardless of when they are effective. Deferred tax assets are reduced, if necessary, by a valuation allowance to the extent future realization of those losses, deductions or other tax benefits is sufficiently uncertain.
Significant judgment is required in determining the provision for income taxes and the related taxes payable and deferred tax assets and liabilities since, in the ordinary course of business, there are transactions and calculations where the ultimate tax outcome is uncertain. Additionally, the Company’s tax returns are subject to audit by various domestic and foreign tax authorities that could result in material adjustments based on differing interpretations of the tax laws. Although management believes that its estimates are reasonable and are based on the best available information at the time the provision is prepared, actual results could differ from these estimates resulting in a final tax outcome that may be materially different from that which is reflected in the consolidated financial statements.

The tax benefit from an uncertain tax position is recognized only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The tax benefits recognized in the consolidated financial statements from such positions are then measured based on the largest

benefit that has a greater than 50% likelihood of being realized upon settlement with the related tax authority. Interest and/or penalties related to uncertain tax positions are recognized in the income tax provision. Significant judgment is required in determining uncertain tax positions. The Company has established accruals for uncertain tax positions using its judgment and adjusts these accruals, as warranted, due to changing facts and circumstances.

New Accounting Pronouncements

See Note 1 ‘‘Significant Accounting Policies’’ included in Item 8 of this 10-K for a description of new accounting pronouncements applicable to the Company.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

The Company's earnings and financial condition are exposed to interest rate risk, credit quality risk, market valuation risk, foreign currency risk, commodity risk and operational risk.

Evaluation of Interest Rate and Credit Quality Risk

The Company manages interest rate risk by seeking to maintain a tight match between the durations of assets and liabilities when appropriate. The Company manages credit quality risk by seeking to maintain high average credit quality ratings and diversified sector exposure within its debt securities portfolio. In connection with its investment and risk management objectives, the Company also uses derivative financial instruments whose market value is at least partially determined by, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets or credit ratings/spreads. The Company's use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps. These instruments, viewed separately, subject the Company to varying degrees of interest rate, equity price and credit risk. However, when used for hedging, the Company expects these instruments to reduce overall risk.

Investments
The Company's investment portfolio supported the following products at December 31, 2020 and 2019:

In millions	**2020**	**2019**
Experience-rated products	$ 1,037	$ 1,100
Remaining products	22,775	18,587
Total investments	$ 23,812	$ 19,687

Investment risks associated with experience-rated products generally do not impact the Company's operating results. The risks associated with investments supporting experience-rated pension and annuity products in the large case pensions business in the Company's Corporate/Other segment are assumed by the contract holders and not by the Company (subject to, among other things, certain minimum guarantees). Assets supporting experience-rated products may be subject to contract holder or participant withdrawals.

The debt securities in the Company's investment portfolio had an average credit quality rating of A at both December 31, 2020 and 2019 with approximately $6.3 billion and $4.4 billion rated AAA at December 31, 2020 and 2019, respectively. The debt securities that were rated below investment grade (that is, having a credit quality rating below BBB-/Baa3) were $1.9 billion and $1.2 billion at December 31, 2020 and 2019, respectively (of which 2% and 4% at December 31, 2020 and 2019, respectively, supported experience-rated products).

At December 31, 2020 and 2019, the Company held $321 million and $333 million, respectively, of municipal debt securities that were guaranteed by third parties, representing 2% of total investments at both December 31, 2020 and 2019. These securities had an average credit quality rating of AA at both December 31, 2020 and 2019 with the guarantee. These securities had an average credit quality rating of A and A+ at December 31, 2020 and 2019, respectively, without the guarantee. The Company does not have any significant concentration of investments with third party guarantors (either direct or indirect).

The Company generally classifies debt securities as available for sale, and carries them at fair value on the consolidated balance sheets. At both December 31, 2020 and 2019, less than 1% of debt securities were valued using inputs that reflect the Company's assumptions (categorized as Level 3 inputs in accordance with accounting principles generally accepted in the United States of America). See Note 4 "Fair Value" included in Item 8 of this 10-K for additional information on the methodologies and key assumptions used to determine the fair value of investments. For additional information related to investments, see Note 3 "Investments" included in Item 8 of this 10-K.

The Company regularly reviews debt securities in its portfolio to determine whether a decline in fair value below the cost basis or carrying value has occurred. If a debt security is in an unrealized loss position and the Company has the intent to sell the security, or it is more likely than not that the Company will have to sell the security before recovery

of its amortized cost basis, the amortized cost basis of the security is written down to its fair value and the difference is recognized in net income. If a debt security is in an unrealized loss position and the Company does not have the intent to sell and it is more likely than not that the Company will not have to sell such security before recovery of its amortized cost basis, the Company bifurcates the impairment into credit-related and non-credit related components. The amount of the credit-related component is recorded as an allowance

for credit losses and recognized in net income, and the amount of the non-credit related component is included in other comprehensive income. The impairment of debt securities is considered a critical accounting policy. See "Critical Accounting Policies - Impairments of Debt Securities" in the MD&A included in Item 7 of this 10-K for additional information.

Evaluation of Market Valuation Risks

The Company regularly evaluates its risk from market-sensitive instruments by examining, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets and/or credit ratings/spreads. The Company also regularly evaluates the appropriateness of investments relative to management-approved investment guidelines (and operates within those guidelines) and the business objectives of its portfolios.

On a quarterly basis, the Company reviews the impact of hypothetical net losses in its investment portfolio on the Company's consolidated near-term financial condition, operating results and cash flows assuming the occurrence of certain reasonably possible changes in near-term market rates and prices. Interest rate changes (whether resulting from changes in treasury yields or credit spreads or other factors) represent the most material risk exposure category for the Company. The Company has estimated the impact on the fair value of market sensitive instruments based on the net present value of cash flows using a representative set of likely future interest rate scenarios. The assumptions used were as follows: an immediate increase of 100 basis points in interest rates (which the Company believes represents a moderately adverse scenario) for long-term debt issued by the Company, as well as its interest rate sensitive investments and an immediate decrease of 15% in prices for publicly traded domestic equity securities.

Assuming an immediate increase of 100 basis points in interest rates, the theoretical decline in the fair values of market sensitive instruments at December 31, 2020 is as follows:

- The fair value of long-term debt issued by the Company would decline by approximately $5.3 billion ($6.7 billion pretax). Changes in the fair value of long-term debt do not impact the Company's operating results or financial condition.
- The theoretical reduction in the fair value of interest rate sensitive investments partially offset by the theoretical reduction in the fair value of interest rate sensitive liabilities would result in a net decline in fair value of approximately $490 million ($615 million pretax) related to continuing non-experience-rated products. Reductions in the fair value of investment securities would be reflected as an unrealized loss in equity, as the Company classifies these debt securities as available for sale. The Company does not record liabilities at fair value.

If the value of the Company's publicly traded domestic equity securities were to decline by 15%, this would result in a net decline in fair value of $5 million ($7 million pretax).

Based on overall exposure to interest rate risk and equity price risk, the Company believes that these changes in market rates and prices would not materially affect consolidated near-term financial condition, operating results or cash flows as of December 31, 2020.

Evaluation of Foreign Currency and Commodity Risk

At December 31, 2020 and 2019, the Company did not have any material foreign currency exchange rate or commodity derivative instruments in place and believes its exposure to foreign currency exchange rate risk is not material.

At December 31, 2020 and 2019, 5.5% and 6.1%, respectively, of the Company's investment portfolio was comprised of investments that have exposure to the oil and gas industry, with more than half that amount comprised of investment grade rated debt securities. These exposures are experiencing varied degrees of financial strains in the current depressed oil and gas price environment, and the likelihood of the Company's portfolio incurring additional realized capital losses on these exposures may increase if such depressed prices persist and/or decline further.

Evaluation of Operational Risks

The Company also faces certain operational risks. Those risks include risks related to the COVID-19 pandemic and risks related to information security, including cybersecurity.

The spread of COVID-19, or actions taken to mitigate its spread, could have material and adverse effects on our ability to operate our businesses effectively, including as a result of the complete or partial closure of facilities or labor shortages. Disruptions in our supply chains, our distribution chains and/or public and private infrastructure, including communications, financial services and supply chains, could materially and adversely impact our business operations. We have transitioned a significant subset of our colleagues to a remote work environment in an effort to mitigate the spread of COVID-19, as have a significant number of our third-party service providers, which may amplify certain risks to our businesses, including an increased demand for information technology resources, increased risk of phishing and other cyber attacks, increased risk of unauthorized dissemination of sensitive personal information or proprietary or confidential information about us or our medical members or other third-parties and increased risk of business interruptions.

The Company and its vendors have experienced diverse cyber attacks and expect to continue to experience cyber attacks going forward. As examples, the Company and its vendors have experienced attempts to gain access to systems, denial of service attacks, attempted malware infections, account takeovers, scanning activity and phishing emails. Attacks can originate from external criminals, terrorists, nation states or internal actors. The Company is dedicating and will continue to dedicate significant resources and incur significant expenses to maintain and update on an ongoing basis the systems and processes that are designed to mitigate the information security risks it faces and protect the security of its computer systems, software, networks and other technology assets against attempts by unauthorized parties to obtain access to confidential information, disrupt or degrade service or cause other damage. The impact of cyber attacks has not been material to the Company's operations or operating results through December 31, 2020. The Board and its Audit Committee and Nominating and Corporate Governance Committee are regularly informed regarding the Company's information security policies, practices and status.

Item 8. Financial Statements and Supplementary Data.

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Consolidated Statements of Operations

In millions, except per share amounts	For the Years Ended December 31, 2020	2019	2018
Revenues:			
Products	$ 190,688	$ 185,236	$ 183,910
Premiums	69,364	63,122	8,184
Services	7,856	7,407	1,825
Net investment income	798	1,011	660
Total revenues	268,706	256,776	194,579
Operating costs:			
Cost of products sold	163,981	158,719	156,447
Benefit costs	55,679	52,529	6,594
Goodwill impairments	—	—	6,149
Operating expenses	35,135	33,541	21,368
Total operating costs	254,795	244,789	190,558
Operating income	13,911	11,987	4,021
Interest expense	2,907	3,035	2,619
Loss on early extinguishment of debt	1,440	79	—
Other income	(206)	(124)	(4)
Income before income tax provision	9,770	8,997	1,406
Income tax provision	2,569	2,366	2,002
Income (loss) from continuing operations	7,201	6,631	(596)
Loss from discontinued operations, net of tax	(9)	—	—
Net income (loss)	7,192	6,631	(596)
Net (income) loss attributable to noncontrolling interests	(13)	3	2
Net income (loss) attributable to CVS Health	$ 7,179	$ 6,634	$ (594)
Basic earnings (loss) per share:			
Income (loss) from continuing operations attributable to CVS Health	$ 5.49	$ 5.10	$ (0.57)
Loss from discontinued operations attributable to CVS Health	$ (0.01)	$ —	$ —
Net income (loss) attributable to CVS Health	$ 5.48	$ 5.10	$ (0.57)
Weighted average basic shares outstanding	1,309	1,301	1,044
Diluted earnings (loss) per share:			
Income (loss) from continuing operations attributable to CVS Health	$ 5.47	$ 5.08	$ (0.57)
Loss from discontinued operations attributable to CVS Health	$ (0.01)	$ —	$ —
Net income (loss) attributable to CVS Health	$ 5.46	$ 5.08	$ (0.57)
Weighted average diluted shares outstanding	1,314	1,305	1,044
Dividends declared per share	$ 2.00	$ 2.00	$ 2.00

See accompanying notes to consolidated financial statements.

Consolidated Statements of Comprehensive Income (Loss)

In millions	For the Years Ended December 31, 2020	2019	2018
Net income (loss)	$ 7,192	$ 6,631	$ (596)
Other comprehensive income (loss), net of tax:			
Net unrealized investment gains	440	677	97
Foreign currency translation adjustments	3	162	(29)
Net cash flow hedges	(31)	(33)	330
Pension and other postretirement benefits	(17)	111	(124)
Other comprehensive income	395	917	274
Comprehensive income (loss)	7,587	7,548	(322)
Comprehensive (income) loss attributable to noncontrolling interests	(13)	3	2
Comprehensive income (loss) attributable to CVS Health	$ 7,574	$ 7,551	$ (320)

See accompanying notes to consolidated financial statements.

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Consolidated Balance Sheets

In millions, except per share amounts	At December 31, 2020	2019
Assets:		
Cash and cash equivalents	$ 7,854	$ 5,683
Investments	3,000	2,373
Accounts receivable, net	21,742	19,617
Inventories	18,496	17,516
Other current assets	5,277	5,113
Total current assets	56,369	50,302
Long-term investments	20,812	17,314
Property and equipment, net	12,606	12,044
Operating lease right-of-use assets	20,729	20,860
Goodwill	79,552	79,749
Intangible assets, net	31,142	33,121
Separate accounts assets	4,881	4,459
Other assets	4,624	4,600
Total assets	$ 230,715	$ 222,449
Liabilities:		
Accounts payable	$ 11,138	$ 10,492
Pharmacy claims and discounts payable	15,795	13,601
Health care costs payable	7,936	6,879
Policyholders' funds	4,270	2,991
Accrued expenses	14,243	12,133
Other insurance liabilities	1,557	1,830
Current portion of operating lease liabilities	1,638	1,596
Current portion of long-term debt	5,440	3,781
Total current liabilities	62,017	53,303
Long-term operating lease liabilities	18,757	18,926
Long-term debt	59,207	64,699
Deferred income taxes	6,794	7,294
Separate accounts liabilities	4,881	4,459
Other long-term insurance liabilities	7,007	7,436
Other long-term liabilities	2,351	2,162
Total liabilities	161,014	158,279
Commitments and contingencies (Note 16)		
Shareholders' equity:		
Preferred stock, par value $0.01: 0.1 shares authorized; none issued or outstanding	—	—
Common stock, par value $0.01: 3,200 shares authorized; 1,733 shares issued and 1,310 shares outstanding at December 31, 2020 and 1,727 shares issued and 1,302 shares outstanding at December 31, 2019 and capital surplus	46,513	45,972
Treasury stock, at cost: 423 and 425 shares at December 31, 2020 and 2019	(28,178)	(28,235)
Retained earnings	49,640	45,108
Accumulated other comprehensive income	1,414	1,019
Total CVS Health shareholders' equity	69,389	63,864
Noncontrolling interests	312	306
Total shareholders' equity	69,701	64,170
Total liabilities and shareholders' equity	$ 230,715	$ 222,449

See accompanying notes to consolidated financial statements.

Consolidated Statements of Cash Flows

In millions	For the Years Ended December 31, 2020	2019	2018
Cash flows from operating activities:			
Cash receipts from customers	$ 264,327	$ 248,393	$ 186,519
Cash paid for inventory and prescriptions dispensed by retail network pharmacies	(158,636)	(149,655)	(148,981)
Insurance benefits paid	(55,124)	(52,242)	(6,897)
Cash paid to other suppliers and employees	(29,763)	(28,932)	(17,234)
Interest and investment income received	894	955	644
Interest paid	(2,904)	(2,954)	(2,803)
Income taxes paid	(2,929)	(2,717)	(2,383)
Net cash provided by operating activities	15,865	12,848	8,865
Cash flows from investing activities:			
Proceeds from sales and maturities of investments	6,467	7,049	817
Purchases of investments	(9,639)	(7,534)	(692)
Purchases of property and equipment	(2,437)	(2,457)	(2,037)
Proceeds from sale-leaseback transactions	101	5	—
Acquisitions (net of cash acquired)	(866)	(444)	(42,226)
Proceeds from sale of subsidiaries and other assets	840	—	832
Other	—	42	21
Net cash used in investing activities	(5,534)	(3,339)	(43,285)
Cash flows from financing activities:			
Net repayments of short-term debt	—	(720)	(556)
Proceeds from issuance of long-term debt	9,958	3,736	44,343
Repayments of long-term debt	(15,631)	(8,336)	(5,522)
Derivative settlements	(7)	(25)	446
Dividends paid	(2,624)	(2,603)	(2,038)
Proceeds from exercise of stock options	264	210	242
Payments for taxes related to net share settlement of equity awards	(88)	(112)	(97)
Other	(27)	—	1
Net cash provided by (used in) financing activities	(8,155)	(7,850)	36,819
Effect of exchange rate changes on cash, cash equivalents and restricted cash	—	—	(4)
Net increase in cash, cash equivalents and restricted cash	2,176	1,659	2,395
Cash, cash equivalents and restricted cash at the beginning of the period	5,954	4,295	1,900
Cash, cash equivalents and restricted cash at the end of the period	$ 8,130	$ 5,954	$ 4,295

In millions	For the Years Ended December 31, 2020	2019	2018
Reconciliation of net income (loss) to net cash provided by operating activities:			
Net income (loss)	$ 7,192	$ 6,631	$ (596)
Adjustments required to reconcile net income (loss) to net cash provided by operating activities:			
Depreciation and amortization	4,441	4,371	2,718
Goodwill impairments	—	—	6,149
Stock-based compensation	400	453	280
(Gain) loss on sale of subsidiaries	(269)	205	86
Loss on early extinguishment of debt	1,440	79	—
Deferred income taxes	(570)	(654)	87
Other noncash items	72	264	253
Change in operating assets and liabilities, net of effects from acquisitions:			
Accounts receivable, net	(1,510)	(2,158)	(1,139)
Inventories	(973)	(1,075)	(1,153)
Other assets	364	(614)	(3)
Accounts payable and pharmacy claims and discounts payable	2,769	3,550	2,329
Health care costs payable and other insurance liabilities	(231)	320	(311)
Other liabilities	2,740	1,476	165
Net cash provided by operating activities	$ 15,865	$ 12,848	$ 8,865

See accompanying notes to consolidated financial statements.

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Consolidated Statements of Shareholders' Equity

	Number of shares outstanding		Attributable to CVS Health						
In millions	**Common Shares**	**Treasury Shares [1]**	**Common Stock and Capital Surplus [2]**	**Treasury Stock [1]**	**Retained Earnings**	**Accumulated Other Comprehensive Income (Loss)**	**Total CVS Health Shareholders' Equity**	**Noncontrolling Interests**	**Total Shareholders' Equity**
Balance at December 31, 2017	**1,712**	**(698)**	**$ 32,096**	**$ (37,796)**	**$ 43,556**	**$ (165)**	**$ 37,691**	**$ 4**	**$ 37,695**
Adoption of new accounting standards [3]	—	—	—	—	(6)	(7)	(13)	—	(13)
Net loss	—	—	—	—	(594)	—	(594)	(2)	(596)
Other comprehensive income (Note 13)	—	—	—	—	—	274	274	—	274
Common shares issued to acquire Aetna	—	274	12,923	9,561	—	—	22,484	—	22,484
Stock option activity, stock awards and other	8	—	421	—	—	—	421	—	421
Purchase of treasury shares, net of ESPP issuances	—	(1)	—	7	—	—	7	—	7
Common stock dividends	—	—	—	—	(2,045)	—	(2,045)	—	(2,045)
Acquisition of noncontrolling interests	—	—	—	—	—	—	—	329	329
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(13)	(13)
Balance at December 31, 2018	1,720	(425)	45,440	(28,228)	40,911	102	58,225	318	58,543
Adoption of new accounting standard [4]	—	—	—	—	178	—	178	—	178
Net income (loss)	—	—	—	—	6,634	—	6,634	(3)	6,631
Other comprehensive income (Note 13)	—	—	—	—	—	917	917	—	917
Stock option activity, stock awards and other	7	2	532	—	—	—	532	—	532
Purchase of treasury shares, net of ESPP issuances	—	(2)	—	(7)	—	—	(7)	—	(7)
Common stock dividends	—	—	—	—	(2,615)	—	(2,615)	—	(2,615)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(9)	(9)
Balance at December 31, 2019	1,727	(425)	45,972	(28,235)	45,108	1,019	63,864	306	64,170
Adoption of new accounting standard (Note 1)	—	—	—	—	(3)	—	(3)	—	(3)
Net income	—	—	—	—	7,179	—	7,179	13	7,192
Other comprehensive income (Note 13)	—	—	—	—	—	395	395	—	395
Stock option activity, stock awards and other	6	—	541	—	—	—	541	—	541
ESPP issuances, net of purchase of treasury shares	—	2	—	57	—	—	57	—	57
Common stock dividends	—	—	—	—	(2,644)	—	(2,644)	—	(2,644)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(7)	(7)
Balance at December 31, 2020	**1,733**	**(423)**	**$ 46,513**	**$ (28,178)**	**$ 49,640**	**$ 1,414**	**$ 69,389**	**$ 312**	**$ 69,701**

(1) Treasury shares include 1 million shares held in trust for each of the years ended December 31, 2020, 2019 and 2018. Treasury stock includes $29 million related to shares held in trust for each of the years ended December 31, 2020, 2019 and 2018. See Note 1 ‘‘Significant Accounting Policies’’ for additional information.

(2) Common stock and capital surplus includes the par value of common stock of $17 million as of December 31, 2020, 2019 and 2018.

(3) Reflects the adoption of Accounting Standards Update (“ASU”) 2014-09, *Revenue from Contracts with Customers*, which resulted in a reduction to retained earnings of $13 million and the adoption of ASU 2018-02, *Income Statement - Reporting Comprehensive Income (Topic 220): Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income*, which resulted in a reduction to accumulated other comprehensive income of $7 million and an increase to retained earnings of $7 million, each during the year ended December 31, 2018.

(4) Reflects the adoption of ASU 2016-02, *Leases* (Topic 842), which resulted in an increase to retained earnings of $178 million during the year ended December 31, 2019.

See accompanying notes to consolidated financial statements.

Notes to Consolidated Financial Statements

1. Significant Accounting Policies

Description of Business

CVS Health Corporation ("CVS Health"), together with its subsidiaries (collectively, the "Company"), has more than 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 105 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year and expanding specialty pharmacy services. The Company also serves an estimated 34 million people through traditional, voluntary and consumer-directed health insurance products and related services, including expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

The coronavirus disease 2019 ("COVID-19") pandemic has severely impacted the economies of the U.S. and other countries around the world. The impact of COVID-19 on the Company's businesses, operating results, cash flows and financial condition in the year ended December 31, 2020, as well as information regarding certain expected impacts of COVID-19 on the Company, is discussed throughout this Annual Report on Form 10-K.

On November 28, 2018 (the "Aetna Acquisition Date"), the Company acquired Aetna Inc. ("Aetna"). As a result of the acquisition of Aetna (the "Aetna Acquisition"), the Company added the Health Care Benefits segment. Certain aspects of Aetna's operations, including products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, are included in the Company's Corporate/Other segment. The consolidated financial statements reflect Aetna's results subsequent to the Aetna Acquisition Date.

The Company has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other, which are described below.

Pharmacy Services Segment
The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services, mail order pharmacy, specialty pharmacy and infusion services, clinical services, disease management services and medical spend management. The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Medicaid managed care plans, plans offered on public health insurance exchanges ("Public Exchanges") and private health insurance exchanges and other sponsors of health benefit plans throughout the United States. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services.

Retail/LTC Segment
The Retail/LTC segment sells prescription drugs and a wide assortment of health and wellness products and general merchandise, provides health care services through its MinuteClinic® walk-in medical clinics, provides medical diagnostic testing, administers vaccinations for illnesses such as influenza, COVID-19 and shingles and conducts long-term care pharmacy ("LTC") operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to long-term care facilities and other care settings. As of December 31, 2020, the Retail/LTC segment operated more than 9,900 retail locations, approximately 1,100 MinuteClinic locations as well as online retail pharmacy websites, LTC pharmacies and on-site pharmacies.

Health Care Benefits Segment
The Health Care Benefits segment is one of the nation's leading diversified health care benefits providers. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make more informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental and behavioral health plans, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services and health information technology

products and services. The Health Care Benefits segment also provided workers' compensation administrative services through its Coventry Health Care Workers' Compensation business ("Workers' Compensation business") prior to the sale of this business on July 31, 2020. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates. The

Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk for medical and dental care costs) as "ASC." For periods prior to the Aetna Acquisition Date, the Health Care Benefits segment was comprised only of the Company's SilverScript® PDP business.

Corporate/Other Segment
The Company presents the remainder of its financial results in the Corporate/Other segment, which primarily consists of:

- Management and administrative expenses to support the Company's overall operations, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments, expenses associated with the Company's investments in its transformation and enterprise modernization programs and acquisition-related transaction and integration costs; and
- Products for which the Company no longer solicits or accepts new customers such as its large case pensions and long-term care insurance products.

Basis of Presentation

The accompanying consolidated financial statements of CVS Health and its subsidiaries have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP"). The consolidated financial statements include the accounts of the Company and its majority-owned subsidiaries and variable interest entities ("VIEs") for which the Company is the primary beneficiary. All material intercompany balances and transactions have been eliminated.

Reclassifications

Certain prior year amounts have been reclassified to conform with the current year presentation.

Use of Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and temporary investments with maturities of three months or less when purchased. The Company invests in short-term money market funds, commercial paper and time deposits, as well as other debt securities that are classified as cash equivalents within the accompanying consolidated balance sheets, as these funds are highly liquid and readily convertible to known amounts of cash.

Restricted Cash

Restricted cash included in other current assets on the consolidated balance sheets represents amounts held in escrow accounts in connection with certain recent acquisitions. Restricted cash included in other assets on the consolidated balance sheets represents amounts held in a trust in one of the Company's captive insurance companies to satisfy collateral requirements associated with the assignment of certain insurance policies. All restricted cash is invested in time deposits, money market funds or commercial paper.

The following is a reconciliation of cash and cash equivalents on the consolidated balance sheets to total cash, cash equivalents and restricted cash on the consolidated statements of cash flows as of December 31, 2020, 2019 and 2018:

In millions	**2020**	**2019**	**2018**
Cash and cash equivalents	$ 7,854	$ 5,683	$ 4,059
Restricted cash (included in other current assets)	—	—	6
Restricted cash (included in other assets)	276	271	230
Total cash, cash equivalents and restricted cash in the consolidated statements of cash flows	$ 8,130	$ 5,954	$ 4,295

Investments

Debt Securities
Debt securities consist primarily of U.S. Treasury and agency securities, mortgage-backed securities, corporate and foreign bonds and other debt securities. Debt securities are classified as either current or long-term investments based on their contractual maturities unless the Company intends to sell an investment within the next twelve months, in which case it is classified as current on the consolidated balance sheets. Debt securities are classified as available for sale and are carried at fair value. See Note 4 ‘‘Fair Value’’ for additional information on how the Company estimates the fair value of these investments.

If a debt security is in an unrealized loss position and the Company has the intent to sell the security, or it is more likely than not that the Company will have to sell the security before recovery of its amortized cost basis, the amortized cost basis of the security is written down to its fair value and the difference is recognized in net income. If a debt security is in an unrealized loss position and the Company does not have the intent to sell and it is more likely than not that the Company will not have to sell such security before recovery of its amortized cost basis, the Company bifurcates the impairment into credit-related and non-credit related components. In evaluating whether a credit related loss exists, the Company considers a variety of factors including: the extent to which the fair value is less than the amortized cost basis; adverse conditions specifically related to the issuer of a security, an industry or geographic area; the payment structure of the security; the failure of the issuer of the security to make scheduled interest or principle payments; and any changes to the rating of the security by a rating agency. The amount of the credit-related component is recorded as an allowance for credit losses and recognized in net income, and the amount of the non-credit related component is included in other comprehensive income. Interest is not accrued on debt securities when management believes the collection of interest is unlikely.

The credit-related component is determined by comparing the present value of cash flows expected to be collected from the security, considering all reasonably available information relevant to the collectability of the security, with the amortized cost basis of the security. If the present value of cash flows expected to be collected is less than the amortized cost basis of the security, the Company records an allowance for credit losses, which is limited by the amount that the fair value is less than amortized cost basis.

For mortgage-backed and other asset-backed securities, the Company recognizes income using an effective yield based on anticipated prepayments and the estimated economic life of the securities. When estimates of prepayments change, the effective yield is recalculated to reflect actual payments to date and anticipated future payments. The Company’s investment in the security is adjusted to the amount that would have existed had the new effective yield been applied since the acquisition of the security, with adjustments recognized in net income.

Equity Securities
Equity securities with readily available fair values are measured at fair value with changes in fair value recognized in net income (loss).

Mortgage Loans
Mortgage loan investments on the consolidated balance sheets are valued at the unpaid principal balance, net of an allowance for credit losses. Mortgage loans with a maturity date or a committed prepayment date within twelve months are classified as current on the consolidated balance sheets. The Company assesses whether its loans share similar risk characteristics and, if so, groups such loans in a risk pool when measuring expected credit losses. The Company considers the following characteristics when evaluating whether its loans share similar risk characteristics: loan-to-value ratios, property type (e.g., office, retail, apartment, industrial), geographic location, vacancy rates and property condition.

Credit loss reserves are determined using a loss rate method that multiplies the unpaid principal balance of each loan within a risk pool group by an estimated loss rate percentage. The loss rate percentage considers both the expected loan loss severity and the probability of loan default. For periods where the Company is able to make or obtain reasonable and supportable forecasts of expected economic conditions (e.g., gross domestic product, employment), the Company adjusts its expected loss rates to reflect these forecasted economic conditions. For periods beyond which the Company is able to make or obtain reasonable and supportable forecasts of expected economic conditions, the Company reverts to historical loss rates in determining expected credit losses.

Interest income on a potential problem loan (i.e., high probability of default) or restructured loan is accrued to the extent it is deemed to be collectible and the loan continues to perform under its original or restructured terms. Interest income on problem loans (i.e., more than 60 days delinquent, in bankruptcy or in process of foreclosure) is recognized on a cash basis. Cash payments on loans in the process of foreclosure are treated as a return of principal.

Other Investments
Other investments consist primarily of the following:

- Private equity and hedge fund limited partnerships, which are accounted for using the equity method of accounting. Under this method, the carrying value of the investment is based on the value of the Company's equity ownership of the underlying investment funds provided by the general partner or manager of the investments, the financial statements of which generally are audited. As a result of the timing of the receipt of the valuation information provided by the fund managers, these investments are generally reported on up to a three month lag. The Company reviews investments for impairment at least quarterly and monitors their performance throughout the year through discussions with the administrators, managers and/or general partners. If the Company becomes aware of an impairment of a limited partnership's investments through its review or prior to receiving the limited partnership's financial statements at the financial statement date, an impairment will be recognized by recording a reduction in the carrying value of the limited partnership with a corresponding charge to net investment income.
- Investment real estate, which is carried on the consolidated balance sheets at depreciated cost, including capital additions, net of write-downs for other-than-temporary declines in fair value. Depreciation is calculated using the straight-line method based on the estimated useful life of each asset. If any real estate investment is considered held-for-sale, it is carried at the lower of its carrying value or fair value less estimated selling costs. The Company generally estimates fair value using a discounted future cash flow analysis in conjunction with comparable sales information. At the time of the sale, the difference between the sales price and the carrying value is recorded as a realized capital gain or loss.
- Privately-placed equity securities, which are carried on the consolidated balance sheets at cost less impairments, plus or minus subsequent adjustments for observable price changes. Additionally, as a member of the Federal Home Loan Bank of Boston ("FHLBB"), a subsidiary of the Company is required to purchase and hold shares of the FHLBB. These shares are restricted and carried at cost.

Net Investment Income
Net investment income on the Company's investments is recorded when earned and is reflected in the Company's net income (other than net investment income on assets supporting experience-rated products). Experience-rated products are products in the large case pensions business where the contract holder, not the Company, assumes investment and other risks, subject to, among other things, minimum guarantees provided by the Company. The effect of investment performance on experience-rated products is allocated to contract holders' accounts daily, based on the underlying investment experience and, therefore, does not impact the Company's net income (as long as the contract's minimum guarantees are not triggered). Net investment income on assets supporting large case pensions' experience-rated products is included in net investment income in the consolidated statements of operations and is credited to contract holders' accounts through a charge to benefit costs.

Realized capital gains and losses on investments (other than realized capital gains and losses on investments supporting experience-rated products) are included as a component of net investment income in the consolidated statements of operations. Realized capital gains and losses are determined on a specific identification basis. Purchases and sales of debt and equity securities and alternative investments are reflected on the trade date. Purchases and sales of mortgage loans and investment real estate are reflected on the closing date.

Realized capital gains and losses on investments supporting large case pensions' experience-rated products are not included in realized capital gains and losses in the consolidated statements of operations and instead are credited directly to contract holders' accounts. The contract holders' accounts are reflected in policyholders' funds on the consolidated balance sheets.

Unrealized capital gains and losses on investments (other than unrealized capital gains and losses on investments supporting experience-rated products) are reflected in shareholders' equity, net of tax, as a component of accumulated other comprehensive income. Unrealized capital gains and losses on investments supporting large case pensions' experience-rated products are credited directly to contract holders' accounts. The contract holders' accounts are reflected in policyholders' funds on the consolidated balance sheets.

Derivative Financial Instruments

The Company uses derivative financial instruments in order to manage interest rate and foreign exchange risk and credit exposure. The Company's use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps.

Accounts Receivable

Accounts receivable are stated net of allowances for credit losses, customer credit allowances, contractual allowances and estimated terminations. Accounts receivable, net is composed of the following at December 31, 2020 and 2019:

In millions	2020	2019
Trade receivables	$ 7,101	$ 6,717
Vendor and manufacturer receivables	9,815	7,856
Premium receivables	2,628	2,663
Other receivables	2,198	2,381
Total accounts receivable, net	$ 21,742	$ 19,617

The Company's allowance for credit losses was $358 million as of December 31, 2020. When developing an estimate of the Company's expected credit losses, the Company considers all available relevant information regarding the collectability of cash flows, including historical information, current conditions and reasonable and supportable forecasts of future economic conditions over the contractual life of the receivable. The Company's accounts receivable are short duration in nature and typically settle in less than 30 days. The Company's allowance for doubtful accounts was $319 million as of December 31, 2019.

Inventories

Inventories are valued at the lower of cost or net realizable value using the weighted average cost method. Physical inventory counts are taken on a regular basis in each retail store and LTC pharmacy, and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the consolidated financial statements are properly stated. During the interim period between physical inventory counts, the Company accrues for anticipated physical inventory losses on a location-by-location basis based on historical results and current physical inventory trends.

Reinsurance Recoverables

The Company utilizes reinsurance agreements primarily to: (a) reduce required capital and (b) facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit the Company to recover a portion of its losses from reinsurers, although they do not discharge the Company's primary liability as the direct insurer of the risks reinsured. Failure of reinsurers to indemnify the Company could result in losses; however, the Company does not expect charges for unrecoverable reinsurance to have a material effect on its consolidated operating results or financial condition. The Company evaluates the financial condition of its reinsurers and monitors concentrations of credit risk arising from similar geographic regions, activities or economic characteristics of its reinsurers. At December 31, 2020, the Company's reinsurance recoverables consisted primarily of amounts due from third parties that are rated consistent with companies that are considered to have the ability to meet their obligations. Reinsurance recoverables are recorded as other current assets or other assets on the consolidated balance sheets.

Health Care Contract Acquisition Costs

Insurance products included in the Health Care Benefits segment are cancelable by either the customer or the member monthly upon written notice. Acquisition costs related to prepaid health care and health indemnity contracts are generally expensed as incurred. Acquisition costs for certain long-duration insurance contracts are deferred and are recorded as other current assets or other assets on the consolidated balance sheets and are amortized over the estimated life of the contracts. The amortization of deferred acquisition costs is recorded in operating expenses in the consolidated statements of operations. At December 31, 2020 and 2019, the balance of deferred acquisition costs was $546 million and $271 million, respectively, comprised primarily of commissions paid on Medicare Supplement products within the Health Care Benefits segment.

Property and Equipment

Property and equipment is reported at historical cost, net of accumulated depreciation. Property, equipment and improvements to leased premises are depreciated using the straight-line method over the estimated useful lives of the

assets, or when applicable, the term of the lease, whichever is shorter. Estimated useful lives generally range from 1 to 40 years for buildings, building improvements and leasehold improvements and 3 to 10 years for fixtures, equipment and internally developed

software. Repair and maintenance costs are charged directly to expense as incurred. Major renewals or replacements that substantially extend the useful life of an asset are capitalized and depreciated. Application development stage costs for significant internally developed software projects are capitalized and depreciated.

Property and equipment consists of the following at December 31, 2020 and 2019:

In millions	**2020**	**2019**
Land	$ 2,134	$ 1,981
Building and improvements	3,950	3,541
Fixtures and equipment	13,125	12,401
Leasehold improvements	6,077	5,611
Software	6,020	5,400
Total property and equipment	31,306	28,934
Accumulated depreciation and amortization	(18,700)	(16,890)
Property and equipment, net	$ 12,606	$ 12,044

Depreciation expense (which includes the amortization of property and equipment under finance or capital leases) totaled $2.1 billion, $1.9 billion and $1.7 billion for the years ended December 31, 2020, 2019 and 2018, respectively. See Note 6 ‘‘Leases’’ for additional information about finance leases.

Right-of-Use Assets and Lease Liabilities

The Company determines if an arrangement contains a lease at the inception of a contract. Right-of-use assets represent the Company’s right to use an underlying asset for the lease term and lease liabilities represent the Company’s obligation to make lease payments arising from the lease. Right-of-use assets and lease liabilities are recognized at the commencement date of the lease, renewal date of the lease or significant remodeling of the lease space based on the present value of the remaining future minimum lease payments. As the interest rate implicit in the Company’s leases is not readily determinable, the Company utilizes its incremental borrowing rate, determined by class of underlying asset, to discount the lease payments. The operating lease right-of-use assets also include lease payments made before commencement and are reduced by lease incentives.

The Company’s real estate leases typically contain options that permit renewals for additional periods of up to five years each. For real estate leases, the options to extend are not considered reasonably certain at lease commencement because the Company reevaluates each lease on a regular basis to consider the economic and strategic incentives of exercising the renewal options and regularly opens or closes stores to align with its operating strategy. Generally, the renewal option periods are not included within the lease term and the associated payments are not included in the measurement of the right-of-use asset and lease liability. Similarly, renewal options are not included in the lease term for non-real estate leases because they are not considered reasonably certain of being exercised at lease commencement. Leases with an initial term of 12 months or less are not recorded on the balance sheets, and lease expense is recognized on a straight-line basis over the term of the short-term lease.

For real estate leases, the Company accounts for lease components and nonlease components as a single lease component. Certain real estate leases require additional payments based on sales volume, as well as reimbursement for real estate taxes, common area maintenance and insurance, which are expensed as incurred as variable lease costs. Other real estate leases contain one fixed lease payment that includes real estate taxes, common area maintenance and insurance. These fixed payments are considered part of the lease payment and included in the right-of-use assets and lease liabilities.

See Note 6 ‘‘Leases’’ for additional information about right-of-use assets and lease liabilities.

Goodwill

The Company accounts for business combinations using the acquisition method of accounting, which requires the excess cost of an acquisition over the fair value of net assets acquired and identifiable intangible assets to be recorded as goodwill. Goodwill is not amortized, but is subject to impairment reviews annually, or more frequently if

necessary, as further described below. See Note 5 ‘‘Goodwill and Other Intangibles’’ for additional information about goodwill.

Intangible Assets

The Company's identifiable intangible assets consist primarily of trademarks, trade names, customer contracts/ relationships, covenants not to compete, technology, provider networks and value of business acquired ("VOBA"). These intangible assets arise primarily from the determination of their respective fair market values at the date of acquisition. Amounts assigned to identifiable intangible assets, and their related useful lives, are derived from established valuation techniques and management estimates.

The Company's definite-lived intangible assets are amortized over their estimated useful lives based upon the pattern of future cash flows attributable to the asset. Other than VOBA, definite-lived intangible assets are amortized using the straight-line method. VOBA is amortized over the expected life of the acquired contracts in proportion to estimated premiums. Indefinite-lived intangible assets are not amortized but are tested for impairment annually, or more frequently if necessary, as further described in "Long-Lived Asset Impairment" below.

See Note 5 ''Goodwill and Other Intangibles'' for additional information about intangible assets.

Long-Lived Asset Impairment

The Company evaluates the recoverability of long-lived assets, excluding goodwill and indefinite-lived intangible assets, which are tested for impairment using separate tests described below, whenever events or changes in circumstances indicate that the carrying value of such asset may not be recoverable. The Company groups and evaluates these long-lived assets for impairment at the lowest level at which individual cash flows can be identified. If indicators of impairment are present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted and without interest charges). If the estimated future cash flows used in this analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group's estimated future cash flows (discounted and with interest charges). If required, an impairment loss is recorded for the portion of the asset group's carrying value that exceeds the asset group's estimated future cash flows (discounted and with interest charges). There were no material impairment charges recognized on long-lived assets in the year ended December 31, 2020. During the year ended December 31, 2019, the Company recorded store rationalization charges of $231 million, primarily related to operating lease right-of-use asset impairment charges. See Note 6 ''Leases'' for additional information about the right-of-use asset impairment charges. During the year ended December 31, 2018, the Company recognized a $43 million long-lived asset impairment charge, primarily related to the impairment of property and equipment.

When evaluating goodwill for potential impairment, the Company compares the fair value of its reporting units to their respective carrying amounts. The Company estimates the fair value of its reporting units using a combination of a discounted cash flow method and a market multiple method. If the carrying amount of a reporting unit exceeds its estimated fair value, an impairment loss is recognized in an amount equal to that excess. During the third quarter of both 2020 and 2019, the Company performed its required annual goodwill impairment tests and concluded there were no goodwill impairments as of the testing dates or during the years ended December 31, 2020 and 2019. See Note 5 ''Goodwill and Other Intangibles'' for additional information about goodwill impairment charges recorded during the year ended December 31, 2018.

Indefinite-lived intangible assets are tested for impairment by comparing the estimated fair value of the asset to its carrying value. The Company estimates the fair value of its indefinite-lived trademarks using the relief from royalty method under the income approach. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized, and the asset is written down to its estimated fair value. There were no impairment losses recognized on indefinite-lived intangible assets in any of the years ended December 31, 2020, 2019 or 2018.

Separate Accounts

Separate Accounts assets and liabilities related to large case pensions products represent funds maintained to meet specific objectives of contract holders who bear the investment risk. These assets and liabilities are carried at fair value. Net investment income (including net realized capital gains and losses) accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from the Company's other businesses. Deposits, withdrawals and net investment income (including net realized and net unrealized capital

gains and losses) on Separate Accounts assets are not reflected in the consolidated statements of operations or cash flows. Management fees charged to contract holders are included in services revenue and recognized over the period earned.

Health Care Costs Payable

Health care costs payable consist principally of unpaid fee-for-service medical, dental and pharmacy claims, capitation costs, other amounts due to providers pursuant to risk-sharing arrangements related to the Health Care Benefits segment's Insured Commercial, Medicare and Medicaid products and accruals for state assessments. Unpaid health care claims include an estimate of payments the Company will make for (i) services rendered to the Company's Insured members but not yet reported to the Company and (ii) claims which have been reported to the Company but not yet paid, each as of the financial statement date (collectively, "IBNR"). Health care costs payable also include an estimate of the cost of services that will continue to be rendered after the financial statement date if the Company is obligated to pay for such services in accordance with contractual or regulatory requirements. Such estimates are developed using actuarial principles and assumptions which consider, among other things, historical and projected claim submission and processing patterns, assumed and historical medical cost trends, historical utilization of medical services, claim inventory levels, changes in Insured membership and product mix, seasonality and other relevant factors. The Company reflects changes in these estimates in benefit costs in the Company's consolidated operating results in the period they are determined. Capitation costs represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the volume of medical services provided to the Insured member. Amounts due under risk-sharing arrangements are based on the terms of the underlying contracts with the providers and consider claims experience under the contracts through the financial statement date.

The Company develops its estimate of IBNR using actuarial principles and assumptions that consider numerous factors. Of those factors, the Company considers the analysis of historical and projected claim payment patterns (including claims submission and processing patterns) and the assumed health care cost trend rate (the year-over-year change in per member per month health care costs) to be the most critical assumptions. In developing its IBNR estimate, the Company consistently applies these actuarial principles and assumptions each period, with consideration to the variability of related factors. There have been no significant changes to the methodologies or assumptions used to develop the Company's estimate of IBNR in 2020.

The Company analyzes historical claim payment patterns by comparing claim incurred dates (i.e., the date services were provided) to claim payment dates to estimate "completion factors." The Company uses completion factors predominantly to estimate the ultimate cost of claims incurred more than three months before the financial statement date. The Company estimates completion factors by aggregating claim data based on the month of service and month of claim payment and estimating the percentage of claims incurred for a given month that are complete by each month thereafter. For any given month, substantially all claims are paid within six months of the date of service, but it can take up to 48 months or longer after the date of service before all of the claims are completely resolved and paid. These historically-derived completion factors are then applied to claims paid through the financial statement date to estimate the ultimate claim cost for a given month's incurred claim activity. The difference between the estimated ultimate claim cost and the claims paid through the financial statement date represents the Company's estimate of claims remaining to be paid as of the financial statement date and is included in the Company's health care costs payable. The completion factors the Company uses reflect judgments and possible adjustments based on data such as claim inventory levels, claim submission and processing patterns and, to a lesser extent, other factors such as changes in health care cost trend rates, changes in Insured membership and changes in product mix. If claims are submitted or processed on a faster (slower) pace than prior periods, the actual claims may be more (less) complete than originally estimated using the Company's completion factors, which may result in reserves that are higher (lower) than the ultimate cost of claims.

Because claims incurred within three months before the financial statement date are less mature, the Company uses a combination of historically-derived completion factors and the assumed health care cost trend rate to estimate the ultimate cost of claims incurred for these months. The Company applies its actuarial judgment and places a greater emphasis on the assumed health care cost trend rate for the most recent claim incurred dates as these months may be influenced by seasonal patterns and changes in membership and product mix.

The Company's health care cost trend rate is affected by changes in per member utilization of medical services as well as changes in the unit cost of such services. Many factors influence the health care cost trend rate, including the Company's ability to manage benefit costs through product design, negotiation of favorable provider contracts and medical management programs, as well as the mix of the Company's business. The health status of the Company's Insured members, aging of the population and other demographic characteristics, advances in medical technology

and other factors continue to contribute to rising per member utilization and unit costs. Changes in health care practices, inflation, new technologies, increases in the cost of prescription drugs (including specialty pharmacy drugs), direct-to-consumer marketing by pharmaceutical companies, clusters of high-cost cases, claim intensity, changes in the regulatory environment, health care provider or member fraud and numerous other factors also contribute to the cost of health care and the Company's health care cost trend rate.

For each reporting period, the Company uses an extensive degree of judgment in the process of estimating its health care costs payable. As a result, considerable variability and uncertainty is inherent in such estimates, particularly with respect to claims with claim incurred dates of three months or less before the financial statement date; and the adequacy of such estimates is highly sensitive to changes in assumed completion factors and the assumed health care cost trend rates. For each reporting period the Company recognizes the actuarial best estimate of health care costs payable considering the potential volatility in assumed completion factors and health care cost trend rates, as well as other factors. The Company believes its estimate of health care costs payable is reasonable and adequate to cover its obligations at December 31, 2020; however, actual claim payments may differ from the Company's estimates. A worsening (or improvement) of the Company's health care cost trend rates or changes in completion factors from those that the Company assumed in estimating health care costs payable at December 31, 2020 would cause these estimates to change in the near term, and such a change could be material.

Each quarter, the Company re-examines previously established health care costs payable estimates based on actual claim payments for prior periods and other changes in facts and circumstances. Given the extensive degree of judgment in this estimate, it is possible that the Company's estimates of health care costs payable could develop either favorably (that is, its actual benefit costs for the period were less than estimated) or unfavorably. The changes in the Company's estimate of health care costs payable may relate to a prior quarter, prior year or earlier periods. For a roll forward of the Company's health care costs payable, see Note 7 ‘‘Health Care Costs Payable.’’ The Company's reserving practice is to consistently recognize the actuarial best estimate of its ultimate liability for health care costs payable.

Other Insurance Liabilities

Unpaid Claims
Unpaid claims consist primarily of reserves associated with certain short-duration group disability and term life insurance contracts, including an estimate for IBNR as of the financial statement date. Reserves associated with certain short-duration group disability and term life insurance contracts are based upon the Company's estimate of the present value of future benefits, which is based on assumed investment yields and assumptions regarding mortality, morbidity and recoveries from the U.S. Social Security Administration. The Company develops its estimate of IBNR using actuarial principles and assumptions which consider, among other things, contractual requirements, claim incidence rates, claim recovery rates, seasonality and other relevant factors. The Company discounts certain claim liabilities related to group long-term disability and life insurance waiver of premium contracts. The discount rates generally reflect the Company's expected investment returns for the investments supporting all incurral years of these liabilities. The discount rates for retrospectively-rated contracts are set at contractually specified levels. The Company's estimates of unpaid claims are subject to change due to changes in the underlying experience of the insurance contracts, changes in investment yields or other factors, and these changes are recorded in current and future benefits in the consolidated statements of operations in the period they are determined. The Company estimates its reserve for claims IBNR for life products largely based on completion factors. The completion factors used are based on the Company's historical experience and reflect judgments and possible adjustments based on data such as claim inventory levels, claim payment patterns, changes in business volume and other factors. If claims are submitted or processed on a faster (slower) pace than historical periods, the actual claims may be more (less) complete than originally estimated using completion factors, which may result in reserves that are higher (lower) than required to cover future life benefit payments. There have been no significant changes to the methodologies or assumptions used to develop the Company's estimate of unpaid claims IBNR in 2020. As of December 31, 2020, unpaid claims balances of $532 million and $1.5 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively. As of December 31, 2019, unpaid claims balances of $704 million and $1.8 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively.

Substantially all life and disability insurance liabilities have been fully ceded to unrelated third parties through indemnity reinsurance agreements; however, the Company remains directly obligated to the policyholders.

Future Policy Benefits
Future policy benefits consist primarily of reserves for limited payment pension and annuity contracts and long-term care insurance contracts. Reserves for limited payment pension and annuity contracts are computed using actuarial principles that consider, among other things, assumptions reflecting anticipated mortality, retirement, expense and interest rate experience. Such assumptions generally vary by plan, year of issue and policy duration. Assumed

interest rates on such contracts ranged from 3.3% to 11.3% in the year ended December 31, 2020 and from 3.5% to 11.3% in the year ended December 31, 2019. The Company periodically reviews mortality assumptions against both industry standards and its experience. Reserves for long-duration long-term care contracts represent the Company's estimate of the present value of future benefits to be paid to or on behalf of policyholders less the present value of future net premiums. The assumed interest rate on such contracts was 5.1% in both the years ended December 31, 2020 and 2019. The Company's estimate of the present value of future benefits under such contracts is based upon mortality, morbidity and interest rate assumptions. As of December 31, 2020, future policy benefits

balances of $462 million and $5.5 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively. As of December 31, 2019, future policy benefits balances of $508 million and $5.6 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively.

Premium Deficiency Reserves

The Company evaluates its insurance contracts to determine if it is probable that a loss will be incurred. A premium deficiency loss is recognized when it is probable that expected future claims, including maintenance costs (for example, direct costs such as claim processing costs), will exceed existing reserves plus anticipated future premiums and reinsurance recoveries. Anticipated investment income is considered in the calculation of premium deficiency losses for short-duration contracts. For purposes of determining premium deficiency losses, contracts are grouped consistent with the Company's method of acquiring, servicing and measuring the profitability of such contracts. As of December 31, 2020 and 2019, the Company established a premium deficiency reserve of $11 million and $4 million, respectively, related to Medicaid products in the Health Care Benefits segment.

Policyholders' Funds

Policyholders' funds consist primarily of reserves for pension and annuity investment contracts and customer funds associated with certain health contracts. Reserves for such contracts are equal to cumulative deposits less withdrawals and charges plus interest credited thereon, net of experience-rated adjustments. In 2020, interest rates for pension and annuity investment contracts ranged from 4.1% to 5.1%. In 2019, interest rates for pension and annuity investment contracts ranged from 3.5% to 5.2%. Reserves for contracts subject to experience rating reflect the Company's rights as well as the rights of policyholders and plan participants. The Company also holds funds for health savings accounts ("HSAs") on behalf of members associated with high deductible health plans. These amounts are held to pay for qualified health care expenses incurred by these members. The HSA balances were approximately $2.7 billion and $2.2 billion at December 31, 2020 and 2019, respectively, and are reflected in other current assets with a corresponding liability in policyholders' funds.

Policyholders' funds liabilities that are expected to be paid within twelve months from the balance sheet date are classified as current on the consolidated balance sheets. Policyholders' funds liabilities that are expected to be paid greater than twelve months from the balance sheet date are included in other long-term liabilities on the consolidated balance sheets.

Self-Insurance Liabilities

The Company is self-insured for certain losses related to general liability, workers' compensation and auto liability. The Company obtains third party insurance coverage to limit exposure from these claims. The Company is also self-insured for certain losses related to health and medical liabilities. The Company's self-insurance accruals, which include reported claims and claims incurred but not reported, are calculated using standard insurance industry actuarial assumptions and the Company's historical claims experience. At December 31, 2020 and 2019, self-insurance liabilities totaled $927 million and $856 million, respectively, and were recorded as accrued expenses on the consolidated balance sheets.

Foreign Currency Translation and Transactions

For non-U.S. dollar functional currency locations, (i) assets and liabilities are translated at end-of-period exchange rates, (ii) revenues and expenses are translated at average exchange rates in effect during the period and (iii) equity is translated at historical exchange rates. The resulting cumulative translation adjustments are included as a component of accumulated other comprehensive income (loss).

For U.S. dollar functional currency locations, foreign currency assets and liabilities are remeasured into U.S. dollars at end-of-period exchange rates, except for nonmonetary balance sheet accounts which are remeasured at historical exchange rates. Revenues and expenses are remeasured at average exchange rates in effect during each period, except for those expenses related to the nonmonetary balance sheet amounts which are remeasured at historical exchange rates. Gains or losses from foreign currency remeasurement are included in net income (loss).

Gains and losses from foreign currency transactions and the effects of foreign currency remeasurements were not material in the years ended December 31, 2020 or 2018. On July 1, 2019, the Company sold its Brazilian subsidiary, Drogaria Onofre Ltda. (“Onofre”) for an immaterial amount. The Company recorded a loss on the divestiture, which included the elimination of the subsidiary’s $154 million cumulative translation adjustment from accumulated other comprehensive income during the year ended December 31, 2019.

Revenue Recognition

Pharmacy Services Segment
The Pharmacy Services segment sells prescription drugs directly through its mail service dispensing pharmacies and indirectly through the Company's retail pharmacy network. The Company's pharmacy benefit arrangements are accounted for in a manner consistent with a master supply arrangement as there are no contractual minimum volumes and each prescription is considered a separate purchasing decision and distinct performance obligation transferred at a point in time. PBM services performed in connection with each prescription claim are considered part of a single performance obligation which culminates in the dispensing of prescription drugs.

The Company recognizes revenue using the gross method at the contract price negotiated with its clients when the Company has concluded it controls the prescription drug before it is transferred to the client plan members. The Company controls prescriptions dispensed indirectly through its retail pharmacy network because it has separate contractual arrangements with those pharmacies, has discretion in setting the price for the transaction and assumes primary responsibility for fulfilling the promise to provide prescription drugs to its client plan members while also performing the related PBM services.

Revenues include (i) the portion of the price the client pays directly to the Company, net of any discounts earned on brand name drugs or other discounts and refunds paid back to the client (see "Drug Discounts" and "Guarantees" below), (ii) the price paid to the Company by client plan members for mail order prescriptions and the price paid to retail network pharmacies by client plan members for retail prescriptions ("retail co-payments"), and (iii) claims based administrative fees for retail pharmacy network contracts. Sales taxes are not included in revenues.

The Company recognizes revenue when control of the prescription drugs is transferred to customers, in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those prescription drugs. The Company has established the following revenue recognition policies for the Pharmacy Services segment:

- Revenues generated from prescription drugs sold by mail service dispensing pharmacies are recognized when the prescription drug is delivered to the client plan member. At the time of delivery, the Company has performed substantially all of its performance obligations under its client contracts and does not experience a significant level of returns or reshipments.
- Revenues generated from prescription drugs sold by third party pharmacies in the Company's retail pharmacy network and associated administrative fees are recognized at the Company's point-of-sale, which is when the claim is adjudicated by the Company's online claims processing system and the Company has transferred control of the prescription drug and performed all of its performance obligations.

For contracts under which the Company acts as an agent or does not control the prescription drugs prior to transfer to the client plan member, revenue is recognized using the net method.

Drug Discounts
The Company records revenue net of manufacturers' rebates earned by its clients based on their plan members' utilization of brand-name formulary drugs. The Company estimates these rebates at period-end based on actual and estimated claims data and its estimates of the manufacturers' rebates earned by its clients. The estimates are based on the best available data at period-end and recent history for the various factors that can affect the amount of rebates due to the client. The Company adjusts its rebates payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. Any cumulative effect of these adjustments is recorded against revenues at the time it is identified. Adjustments generally result from contract changes with clients or manufacturers that have retroactive rebate adjustments, differences between the estimated and actual product mix subject to rebates, or whether the brand name drug was included in the applicable formulary. The effect of adjustments between estimated and actual manufacturers' rebate amounts has not been material to the Company's operating results or financial condition.

Guarantees
The Company also adjusts revenues for refunds owed to clients resulting from pricing guarantees and performance against defined service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Retail/LTC Segment

Retail Pharmacy

The Company's retail drugstores recognize revenue at the time the customer takes possession of the merchandise. For pharmacy sales, each prescription claim is its own arrangement with the customer and is a performance obligation, separate and distinct from other prescription claims under other retail network arrangements. Revenues are adjusted for refunds owed to third party payers resulting from pricing guarantees and performance against defined value-based service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Revenue from Company gift cards purchased by customers is deferred as a contract liability until goods or services are transferred. Any amounts not expected to be redeemed by customers (i.e., breakage) are recognized based on historical redemption patterns.

Customer returns are not material to the Company's operating results or financial condition. Sales taxes are not included in revenues.

Loyalty and Other Programs

The Company's customer loyalty program, ExtraCare®, consists of two components, ExtraSavings™ and ExtraBucks® Rewards. ExtraSavings are coupons that are recorded as a reduction of revenue when redeemed as the Company concluded that they do not represent a promise to the customer to deliver additional goods or services at the time of issuance because they are not tied to a specific transaction or spending level.

ExtraBucks Rewards are accumulated by customers based on their historical spending levels. Thus, the Company has determined that there is an additional performance obligation to those customers at the time of the initial transaction. The Company allocates the transaction price to the initial transaction and the ExtraBucks Rewards transaction based upon the relative standalone selling price, which considers historical redemption patterns for the rewards. Revenue allocated to ExtraBucks Rewards is recognized as those rewards are redeemed. At the end of each period, unredeemed ExtraBucks Rewards are reflected as a contract liability.

The Company also offers a subscription-based membership program, CarePass®, under which members are entitled to a suite of benefits delivered over the course of the subscription period, as well as a promotional reward that can be redeemed for future goods and services. Subscriptions are paid for on a monthly or annual basis at the time of or in advance of the Company delivering the goods and services. Revenue from these arrangements is recognized as the performance obligations are satisfied.

Long-term Care

Revenue is recognized when control of the promised goods or services is transferred to customers in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those goods or services. Each prescription claim represents a separate performance obligation of the Company, separate and distinct from other prescription claims under customer arrangements. A significant portion of Long-term Care revenue from sales of pharmaceutical and medical products is reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. The Company monitors its revenues and receivables from these reimbursement sources, as well as long-term care facilities and other third party insurance payors, and reduces revenue at the revenue recognition date to properly account for the variable consideration due to anticipated differences between billed and reimbursed amounts. Accordingly, the total revenues and receivables reported in the Company's consolidated financial statements are recorded at the amount expected to be ultimately received from these payors.

Patient co-payments associated with Medicare Part D, certain state Medicaid programs, Medicare Part B and certain third party payors typically are not collected at the time products are delivered or services are rendered, but are billed to the individuals as part of normal billing procedures and subject to normal accounts receivable collections procedures.

Walk-In Medical Clinics

For services provided by the Company's walk-in medical clinics, revenue recognition occurs for completed services provided to patients, with adjustments taken for third party payor contractual obligations and patient direct bill historical collection rates.

Health Care Benefits Segment
Health Care Benefits revenue is principally derived from insurance premiums and fees billed to customers. Revenue is recognized based on customer billings, which reflect contracted rates per employee and the number of covered employees

recorded in the Company's records at the time the billings are prepared. Billings are generally sent monthly for coverage during the following month.

The Company's billings may be subsequently adjusted to reflect enrollment changes due to member terminations or other factors. These adjustments are known as retroactivity adjustments. In each period, the Company estimates the amount of future retroactivity and adjusts the recorded revenue accordingly. As information regarding actual retroactivity amounts becomes known, the Company refines its estimates and records any required adjustments to revenues in the period in which they arise.

Premium Revenue

Premiums are recognized as revenue in the month in which the enrollee is entitled to receive health care services. Premiums are reported net of an allowance for estimated terminations and uncollectible amounts. Additionally, premium revenue subject to the minimum medical loss ratio ("MLR") rebate requirements of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (as amended, collectively, the "ACA") is recorded net of the estimated minimum MLR rebates for the current calendar year. Premiums related to unexpired contractual coverage periods (unearned premiums) are reported as other insurance liabilities on the consolidated balance sheets and recognized as revenue when earned.

Some of the Company's contracts allow for premiums to be adjusted to reflect actual experience or the relative health status of Insured members. Such adjustments are reasonably estimable at the outset of the contract, and adjustments to those estimates are made based on actual experience of the customer emerging under the contract and the terms of the underlying contract.

Services Revenue

Services revenue relates to contracts that can include various combinations of services or series of services which generally are capable of being distinct and accounted for as separate performance obligations. The Health Care Benefits segment's services revenue primarily consists of ASC fees received in exchange for performing certain claim processing and member services for ASC members. ASC fee revenue is recognized over the period the service is provided. Some of the Company's administrative services contracts include guarantees with respect to certain functions, such as customer service response time, claim processing accuracy and claim processing turnaround time, as well as certain guarantees that a plan sponsor's benefit claim experience will fall within a certain range. With any of these guarantees, the Company is financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk typically is limited to a percentage of the fees otherwise payable to the Company by the customer involved. Each period the Company estimates its obligations under the terms of these guarantees and records its estimate as an offset to services revenues.

Accounting for Medicare Part D

Revenues include insurance premiums earned by the Company's PDPs, which are determined based on the PDP's annual bid and related contractual arrangements with the U.S. Centers for Medicare & Medicaid Services ("CMS"). The insurance premiums include a beneficiary premium, which is the responsibility of the PDP member, and can be subsidized by CMS in the case of low-income members, and a direct premium paid by CMS. Premiums collected in advance are initially recorded within other insurance liabilities and are then recognized ratably as revenue over the period in which members are entitled to receive benefits.

Revenues also include a risk-sharing feature of the Medicare Part D program design referred to as the risk corridor. The Company estimates variable consideration in the form of amounts payable to, or receivable from, CMS under the risk corridor, and adjusts revenue based on calculations of additional subsidies to be received from or owed to CMS at the end of the reporting year.

In addition to Medicare Part D premiums, the Company receives additional payments each month from CMS related to catastrophic reinsurance, low-income cost-sharing subsidies and coverage gap benefits. If the subsidies received differ from the amounts earned from actual prescriptions transferred, the difference is recorded in either accounts receivable, net or accrued expenses.

Disaggregation of Revenue
The following table disaggregates the Company's revenue by major source in each segment for the years ended December 31, 2020, 2019 and 2018:

In millions	Pharmacy Services	Retail/ LTC	Health Care Benefits	Corporate/ Other	Intersegment Eliminations	Consolidated Totals
2020						
Major goods/services lines:						
Pharmacy	$ 141,116	$ 70,176	$ —	$ —	$ (40,003)	$ 171,289
Front Store	—	19,655	—	—	—	19,655
Premiums	—	—	69,301	63	—	69,364
Net investment income	—	—	483	315	—	798
Other	822	1,367	5,683	48	(320)	7,600
Total	$ 141,938	$ 91,198	$ 75,467	$ 426	$ (40,323)	$ 268,706
Pharmacy Services distribution channel:						
Pharmacy network [1]	$ 85,045					
Mail choice [2]	56,071					
Other	822					
Total	$ 141,938					
2019						
Major goods/services lines:						
Pharmacy [3]	$ 140,896	$ 66,442	$ —	$ —	$ (41,413)	$ 165,925
Front Store	—	19,422	—	—	—	19,422
Premiums	—	—	63,031	91	—	63,122
Net investment income	—	—	599	412	—	1,011
Other [3]	595	744	5,974	9	(26)	7,296
Total	$ 141,491	$ 86,608	$ 69,604	$ 512	$ (41,439)	$ 256,776
Pharmacy Services distribution channel:						
Pharmacy network [1]	$ 88,755					
Mail choice [2]	52,141					
Other	595					
Total	$ 141,491					
2018						
Major goods/services lines:						
Pharmacy	$ 134,216	$ 64,179	$ 164	$ —	$ (33,714)	$ 164,845
Front Store	—	19,055	—	—	—	19,055
Premiums	—	—	8,180	4	—	8,184
Net investment income	—	—	58	602	—	660
Other	520	755	560	—	—	1,835
Total	$ 134,736	$ 83,989	$ 8,962	$ 606	$ (33,714)	$ 194,579
Pharmacy Services distribution channel:						
Pharmacy network [1]	$ 87,167					
Mail choice [2]	47,049					
Other	520					
Total	$ 134,736					

(1) Pharmacy Services pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including the Company's retail pharmacies and LTC pharmacies, but excluding Maintenance Choice® activity, which is included within the mail choice category. Maintenance Choice permits eligible client plan members to fill their maintenance prescriptions through mail order delivery or at a CVS pharmacy retail store for the same price as mail order.

(2) Pharmacy Services mail choice is defined as claims filled at a Pharmacy Services mail order facility, which includes specialty mail claims inclusive of Specialty Connect® claims picked up at a retail pharmacy, as well as prescriptions filled at the Company's retail pharmacies under the Maintenance Choice program.

(3) Certain prior year amounts have been reclassified for consistency with the current period presentation.

Contract Balances

Contract liabilities primarily represent the Company's obligation to transfer additional goods or services to a customer for which the Company has received consideration, and include ExtraBucks Rewards and unredeemed Company gift cards. The consideration received remains a contract liability until goods or services have been provided to the customer. In addition, the Company recognizes breakage on Company gift cards based on historical redemption patterns.

The following table provides information about receivables and contract liabilities from contracts with customers as of December 31, 2020 and 2019:

In millions	**2020**	**2019**
Trade receivables (included in accounts receivable, net)	$ 7,101	$ 6,717
Contract liabilities (included in accrued expenses)	71	73

During the years ended December 31, 2020 and 2019, the contract liabilities balance includes increases related to customers' earnings in ExtraBucks Rewards or issuances of Company gift cards and decreases for revenues recognized during the period as a result of the redemption of ExtraBucks Rewards or Company gift cards and breakage of Company gift cards. Below is a summary of such changes:

In millions	**2020**	**2019**
Contract liabilities, beginning of period	$ 73	$ 67
Rewards earnings and gift card issuances	357	365
Redemption and breakage	(359)	(359)
Contract liabilities, end of period	$ 71	$ 73

Cost of Products Sold

The Company accounts for cost of products sold as follows:

Pharmacy Services Segment

Cost of products sold includes: (i) the cost of prescription drugs sold during the reporting period directly through the Company's mail service dispensing pharmacies and indirectly through the Company's retail pharmacy network, (ii) shipping and handling costs, and (iii) the operating costs of the Company's mail service dispensing pharmacies and client service operations and related information technology support costs including depreciation and amortization. The cost of prescription drugs sold component of cost of products sold includes: (i) the cost of the prescription drugs purchased from manufacturers or distributors and shipped to members in clients' benefit plans from the Company's mail service dispensing pharmacies, net of any volume-related or other discounts (see "Vendor Allowances and Purchase Discounts" below) and (ii) the cost of prescription drugs sold (including retail co-payments) through the Company's retail pharmacy network under contracts where the Company is the principal, net of any volume-related or other discounts.

Retail/LTC Segment

Cost of products sold includes: the cost of merchandise sold during the reporting period, including prescription drug costs, and the related purchasing costs, warehousing and delivery costs (including depreciation and amortization) and actual and estimated inventory losses.

Vendor Allowances and Purchase Discounts

The Company accounts for vendor allowances and purchase discounts as follows:

Pharmacy Services Segment
The Pharmacy Services segment receives purchase discounts on products purchased. Contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for the Pharmacy Services segment to receive purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These rebates are recognized when prescriptions are dispensed and are generally calculated and billed to manufacturers within 30 days of the end of each completed quarter. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material to the Company's operating results or financial condition. The Company accounts for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. The Pharmacy Services segment also receives additional discounts under its wholesaler contracts if it exceeds contractually defined purchase volumes. In addition, the Pharmacy Services segment receives fees from pharmaceutical manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of cost of products sold.

Retail/LTC Segment
Vendor allowances received by the Retail/LTC segment reduce the carrying cost of inventory and are recognized in cost of products sold when the related inventory is sold, unless they are specifically identified as a reimbursement of incremental costs for promotional programs and/or other services provided. Amounts that are directly linked to advertising commitments are recognized as a reduction of advertising expense (included in operating expenses) when the related advertising commitment is satisfied. Any amounts received in excess of the actual cost incurred also reduce the carrying cost of inventory. The total value of any upfront payments received from vendors that are linked to purchase commitments is initially deferred. The deferred amounts are then amortized to reduce cost of products sold over the life of the contract based upon purchase volume. The total value of any upfront payments received from vendors that are not linked to purchase commitments is also initially deferred. The deferred amounts are then amortized to reduce cost of products sold on a straight-line basis over the life of the related contract. The total amortization of these upfront payments was not material to the Company's consolidated financial statements in any of the periods presented.

Health Care Reform

Health Insurer Fee
Since January 1, 2014, the ACA has imposed an annual premium-based health insurer fee ("HIF") for each calendar year, payable in September, which was not deductible for tax purposes. The Company has been required to estimate a liability for the HIF at the beginning of the calendar year in which the fee was payable with a corresponding deferred asset that was amortized ratably to operating expenses over the calendar year. The Company recorded the liability for the HIF in accrued expenses and recorded the deferred asset in other current assets. In the years ended December 31, 2020 and 2018, operating expenses included $1.0 billion and $157 million, respectively, related to the Company's share of the HIF. There was no expense related to the HIF in 2019, since there was a one-year suspension of the HIF for 2019. In December 2019, the HIF was repealed for calendar years after 2020.

Risk Adjustment
The ACA established a permanent risk adjustment program to transfer funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of the Company's qualified plan members relative to the average risk of members of other qualified plans in comparable markets, as defined by the ACA, the Company estimates its ultimate risk adjustment receivable (recorded in accounts receivable) or payable (recorded in accrued expenses) for the current calendar year and reflects the pro-rata year-to-date impact as an adjustment to premium revenue.

Risk Corridor
The ACA established a temporary risk corridor program, which expired at the end of 2016, for qualified individual and small group health insurance plans. Under this program, health insurance companies were to make payments to, or receive payments from, the U.S. Department of Health and Human Services ("HHS") based on their ratio of allowable costs to target costs (as defined by the ACA).

The Company filed a lawsuit in August 2019 to recover the $313 million it was owed under the ACA's risk corridor program, which had been stayed pending the Supreme Court decision. In April 2020, the U.S. Supreme Court ruled that health insurance companies may sue the federal government for amounts owed as calculated under the ACA's temporary risk corridor program.

In October 2020, the Company received the $313 million it was owed under the ACA's risk corridor program. The Company recorded the risk corridor payment as an increase to premium revenue in the year ended December 31, 2020. After considering offsetting items such as the ACA's minimum MLR rebate requirements and premium taxes, the Company recorded pre-tax income of $307 million and after-tax income of $223 million during the year ended December 31, 2020.

At December 31, 2019, the Company did not record any ACA risk corridor receivables because payment was uncertain.

Advertising Costs

Advertising costs, which are reduced by the portion funded by vendors, are expensed when the related advertising takes place. Net advertising costs, which are included in operating expenses, were $461 million, $396 million and $364 million in 2020, 2019 and 2018, respectively.

Stock-Based Compensation

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as expense over the requisite service period of the stock award (generally three to five years) using the straight-line method.

Income Taxes

The Company accounts for income taxes under the asset and liability method, which requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of events that have been included in the consolidated financial statements. Under this method, deferred tax assets and liabilities are determined on the basis of the differences between the consolidated financial statements and tax basis of assets and liabilities using enacted tax rates in effect for the year or years in which the differences are expected to reverse. The effect of a change in the tax rates on deferred tax assets and liabilities is recognized in income in the period that includes the enactment date of such change.
The Tax Cuts and Jobs Act (the "TCJA") was enacted on December 22, 2017. Among numerous changes to existing tax laws, the TCJA permanently reduced the federal corporate income tax rate from 35% to 21% effective January 1, 2018. The effects of changes in tax rates on deferred tax balances are required to be taken into consideration in the period in which the changes are enacted, regardless of when they are effective. As a result of the reduction of the corporate income tax rate under the TCJA, the Company estimated the revaluation of its net deferred tax liabilities and recorded a provisional income tax benefit of approximately $1.5 billion for year ended December 31, 2017. In 2018, the Company completed its process of determining the TCJA's final impact and recorded an additional income tax benefit of $100 million.

The Company recognizes deferred tax assets to the extent that it believes these assets are more likely than not to be realized. In making such a determination, the Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax planning strategies, and the Company's recent operating results. The Company establishes a valuation allowance when it does not consider it more likely than not that a deferred tax asset will be recovered.

The Company records uncertain tax positions on the basis of a two-step process whereby (1) the Company determines whether it is more likely than not that the tax positions will be sustained on the basis of the technical merits of the position and (2) for those tax positions that meet the more-likely-than-not recognition threshold, the Company recognizes the largest amount of tax benefit that is more than 50% likely to be realized upon ultimate settlement with the related tax authority.

Interest and/or penalties related to uncertain tax positions are recognized in the income tax provision.

Measurement of Defined Benefit Pension and Other Postretirement Employee Benefit Plans

The Company sponsors defined benefit pension plans ("pension plans") and other postretirement employee benefit plans ("OPEB plans") for its employees and retirees. The Company recognizes the funded status of its pension and

OPEB plans on the consolidated balance sheets based on the year-end measurements of plan assets and benefit obligations. When the fair value of plan assets are in excess of the plan benefit obligations, the amounts are reported in other current assets and other assets. When the fair value of plan benefit obligations are in excess of plan assets, the amounts are reported in accrued expenses and other long-term liabilities based on the amount by which the actuarial present value of benefits payable in the next twelve months included in the benefit obligation exceeds the fair value of plan assets. The net periodic benefit cost (income) for the Company's pension and OPEB plans do not contain a service cost component as these plans have been frozen for an extended

period of time. Non-service cost components of pension and postretirement net periodic benefit cost (income) are included in other income in the consolidated statements of operations.

Earnings (Loss) per Common Share

Earnings (loss) per share is computed using the two-class method. The Company calculates basic earnings (loss) per share based on the weighted average number of common shares outstanding for the period. See Note 14 ‘‘Earnings (Loss) Per Share’’ for additional information.

Shares Held in Trust

The Company maintains grantor trusts, which held approximately one million shares of its common stock at both December 31, 2020 and 2019. These shares are designated for use under various employee compensation plans. Since the Company holds these shares, they are excluded from the computation of basic and diluted shares outstanding.

Variable Interest Entities

The Company has investments in (i) a generic pharmaceutical sourcing entity, (ii) certain hedge fund and private equity investments and (iii) certain real estate partnerships that are considered VIEs. The Company does not have a future obligation to fund losses or debts on behalf of these investments; however, it may voluntarily contribute funds. In evaluating whether the Company is the primary beneficiary of a VIE, the Company considers several factors, including whether the Company has (a) the power to direct the activities that most significantly impact the VIE’s economic performance and (b) the obligation to absorb losses and the right to receive benefits that could potentially be significant to the VIE.

Variable Interest Entities - Primary Beneficiary
In 2014, the Company and Cardinal Health, Inc. (“Cardinal”) established Red Oak Sourcing, LLC (“Red Oak”), a generic pharmaceutical sourcing entity in which the Company and Cardinal each own 50%. The Red Oak arrangement has an initial term of 10 years. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak; however, Red Oak does not own or hold inventory on behalf of either company. No physical assets (e.g., property and equipment) were contributed to Red Oak by either company, and minimal funding was provided to capitalize Red Oak. The Company has determined that it is the primary beneficiary of this VIE because it has the ability to direct the activities of Red Oak. Consequently, the Company consolidates Red Oak in its consolidated financial statements within the Retail/LTC segment.

Cardinal is required to pay the Company 39 quarterly payments beginning in October 2014. As milestones are met, the quarterly payments increase. The Company received from Cardinal $183 million during each of the years ended December 31, 2020, 2019 and 2018. The payments reduce the Company’s carrying value of inventory and are recognized in cost of products sold when the related inventory is sold. Revenues associated with Red Oak expenses reimbursed by Cardinal for the years ended December 31, 2020, 2019 and 2018, and amounts due to or due from Cardinal at December 31, 2020 and 2019 were immaterial.

Variable Interest Entities - Other Variable Interest Holder
The Company has invested in certain VIEs for which it has determined that it is not the primary beneficiary, consisting of the following:

- *Hedge fund and private equity investments* - The Company invests in hedge fund and private equity investments in order to generate investment returns for its investment portfolio supporting its insurance businesses.
- *Real estate partnerships* - The Company invests in various real estate partnerships, including those that construct, own and manage low-income housing developments. For the low income housing development investments, substantially all of the projected benefits to the Company are from tax credits and other tax benefits.

The Company is not the primary beneficiary of these VIEs because the nature of the Company’s involvement with the activities of these VIEs does not give the Company the power to direct the activities that most significantly

impact their economic performance. The Company records the amount of its investment in these VIEs as long-term investments on the consolidated balance sheets and recognizes its share of each VIE's income or losses in net income (loss). The Company's maximum exposure to loss from these VIEs is limited to its investment balances as disclosed below and the risk of recapture of previously recognized tax credits related to the real estate partnerships, which the Company does not consider significant.

The total amount of other variable interest holder VIE assets included in long-term investments on the consolidated balance sheets at December 31, 2020 and 2019 was as follows:

In millions	**2020**	**2019**
Hedge fund investments	$ 342	$ 271
Private equity investments	547	538
Real estate partnerships	200	212
Total	$ 1,089	$ 1,021

Related Party Transactions

The Company has an equity method investment in SureScripts, LLC ("SureScripts"), which operates a clinical health information network. The Company utilizes this clinical health information network in providing services to its client plan members and retail customers. The Company expensed fees for the use of this network of $56 million, $32 million and $45 million in the years ended December 31, 2020, 2019 and 2018, respectively. The Company's investment in and equity in the earnings of SureScripts for all periods presented is immaterial.

The Company has an equity method investment in Heartland Healthcare Services, LLC ("Heartland"). Heartland operates several LTC pharmacies in four states. Heartland paid the Company $77 million, $96 million and $135 million for pharmaceutical inventory purchases during the years ended December 31, 2020, 2019 and 2018, respectively. Additionally, the Company performs certain collection functions for Heartland and then transfers those customer cash collections to Heartland. The Company's investment in and equity in the earnings of Heartland for all periods presented is immaterial.

During the years ended December 31, 2020 and 2019, the Company made charitable contributions of $50 million and $30 million, respectively, to the CVS Health Foundation, a non-profit entity that focuses on health, education and community involvement programs. The charitable contributions were recorded as operating expenses in the consolidated statements of operations within the Corporate/Other segment for the years ended December 31, 2020 and 2019.

Discontinued Operations

In connection with certain business dispositions completed between 1995 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Linens 'n Things and Bob's Stores, each of which subsequently filed for bankruptcy. The Company's loss from discontinued operations includes lease-related costs that the Company believes it will likely be required to satisfy pursuant to these lease guarantees. See "Lease Guarantees" in Note 16 ''Commitments and Contingencies'' for additional information.

Below is a summary of the results of discontinued operations for the year ended December 31, 2020.

In millions	**2020**
Loss from discontinued operations	$ (12)
Income tax benefit	3
Loss from discontinued operations, net of tax	$ (9)

Results from discontinued operations were immaterial for the years ended December 31, 2019 and 2018.

New Accounting Pronouncements Recently Adopted

Measurement of Credit Losses on Financial Instruments
In June 2016, the Financial Accounting Standards Board ("FASB") issued ASU 2016-13, *Financial Instruments - Credit Losses* (Topic 326). This standard requires the use of a forward-looking expected credit loss impairment model for trade and other receivables, held-to-maturity debt securities, loans and other instruments. This standard also requires impairments and recoveries for available-for-sale debt securities to be recorded through an allowance

account and revises certain disclosure requirements. The Company adopted this new accounting standard on January 1, 2020. The Company adopted the credit loss impairment model on a modified retrospective basis and recorded a $3 million cumulative effect adjustment to reduce retained earnings as of the adoption date. The Company adopted the available-for-sale debt security impairment model on a prospective

basis. The adoption of this standard did not have a material impact on the Company's consolidated operating results, cash flows or financial condition.

Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract
In August 2018, the FASB issued ASU 2018-15, *Intangibles - Goodwill and other - Internal-Use Software* (Topic 350-40): *Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract.* This standard requires a customer in a cloud computing arrangement that is a service contract to follow the internal-use software guidance in Topic 350-40 to determine which implementation costs to capitalize as assets. The Company adopted this new accounting guidance on January 1, 2020 on a prospective basis. The adoption of this standard did not have a material impact on the Company's consolidated operating results, cash flows, financial condition or related disclosures.

New Accounting Pronouncements Not Yet Adopted

Simplifying the Accounting for Income Taxes
In December 2019, the FASB issued ASU 2019-12, *Simplifying the Accounting for Income Taxes* (Topic 740). This standard simplifies the accounting for income taxes by eliminating certain exceptions to the guidance in Accounting Standards Codification ("ASC") 740 related to the approach for intraperiod tax allocation, the methodology for calculating income taxes in an interim period and the recognition of deferred tax liabilities for outside basis differences. The standard also simplifies aspects of the accounting for franchise taxes and enacted changes in tax laws or rates and clarifies the accounting for transactions that result in a step-up in the tax basis of goodwill. The Company adopted this new accounting standard on January 1, 2021. The adoption of this standard did not have a material impact on the Company's consolidated operating results, cash flows, financial condition or related disclosures.

Targeted Improvements to the Accounting for Long-Duration Insurance Contracts
In August 2018, the FASB issued ASU 2018-12, *Targeted Improvements to the Accounting for Long-Duration Contracts* (Topic 944). This standard requires the Company to review cash flow assumptions for its long-duration insurance contracts at least annually and recognize the effect of changes in future cash flow assumptions in net income. This standard also requires the Company to update discount rate assumptions quarterly and recognize the effect of changes in these assumptions in other comprehensive income. The rate used to discount the Company's liability for future policy benefits will be based on an estimate of the yield for an upper-medium grade fixed-income instrument with a duration profile matching that of the Company's liabilities. In addition, this standard changes the amortization method for deferred acquisition costs and requires additional disclosures regarding the long duration insurance contract liabilities in the Company's interim and annual financial statements. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2022. The Company is currently evaluating the effect that implementation of this standard will have on the Company's consolidated operating results, cash flows, financial condition and related disclosures.

2. Acquisitions and Divestitures

Acquisition of Aetna

On the Aetna Acquisition Date, the Company acquired 100% of the outstanding shares and voting interests of Aetna for a combination of cash and stock. Under the terms of the merger agreement, Aetna shareholders received $145.00 in cash and 0.8378 CVS Health shares for each Aetna share. The transaction valued Aetna at approximately $212 per share or approximately $70 billion. Including the assumption of Aetna's debt, the total value of the transaction was approximately $78 billion. The Company financed the cash portion of the purchase price through a combination of cash on hand and by issuing approximately $45 billion of new debt, including senior notes and term loans. The Company acquired Aetna to help improve the consumer health care experience by combining Aetna's health care benefits products and services with CVS Health's more than 9,900 retail locations, approximately 1,100 walk-in medical clinics and integrated pharmacy capabilities with the goal of becoming the new, trusted front door to health care.

The transaction has been accounted for using the acquisition method of accounting which requires, among other things, the assets acquired and liabilities assumed to be recognized at their fair values at the date of acquisition. The following table summarizes the fair values of the assets acquired and liabilities assumed at the date of acquisition:

In millions	
Cash and cash equivalents	$ 6,565
Accounts receivable	4,094
Other current assets	3,894
Investments (current and long-term)	17,984
Goodwill	47,755
Intangible assets	22,571
Other assets	8,249
Total assets acquired	111,112
Health care costs payable	5,302
Other current liabilities	9,940
Debt (current and long-term)	8,098
Deferred income taxes	4,608
Other long-term liabilities	13,078
Total liabilities assumed	41,026
Noncontrolling interests	320
Total consideration transferred	$ 69,766

The Company's assessment of the fair value of assets acquired and liabilities assumed was finalized during the fourth quarter of 2019. Measurement period adjustments to assets acquired and liabilities assumed during the year ended December 31, 2019 primarily were due to additional information received related to certain intangible asset valuations and contingencies and the related impact on the accounting for income taxes and goodwill. There were no material income statement measurement period adjustments recorded during the year ended December 31, 2019.

Consolidated Results of Operations

The Company's consolidated operating results for the year ended December 31, 2018, included $5.6 billion of revenues and $146 million of income before income tax provision associated with the operating results of Aetna from the Aetna Acquisition Date to December 31, 2018. During the year ended December 31, 2018, the Company incurred transaction costs of $147 million associated with the Aetna Acquisition that were recorded within operating expenses.

Unaudited Pro Forma Financial Information

The following unaudited pro forma information presents a summary of the Company's combined operating results for the year ended December 31, 2018 as if the Aetna acquisition and the related financing transactions had occurred on January 1, 2018. The following pro forma financial information is not necessarily indicative of the Company's operating results as they would have been had the acquisition been effected on the assumed date, nor is it necessarily an indication of trends in future results for a number of reasons, including differences between the assumptions used to prepare the pro forma financial information, basic shares outstanding and dilutive equivalents, cost savings from operating efficiencies, potential synergies, and the impact of incremental costs incurred in integrating the businesses.

In millions, except per share data	**Year Ended December 31, 2018**
Total revenues	$ 243,232
Income from continuing operations	1,152
Basic earnings per share from continuing operations attributable to CVS Health	$ 0.89
Diluted earnings per share from continuing operations attributable to CVS Health	$ 0.88

The pro forma results for the year ended December 31, 2018 include adjustments related to the following purchase accounting and acquisition-related items:

- Elimination of intercompany transactions between CVS Health and Aetna;
- Elimination of estimated foregone interest income associated with (i) cash assumed to have been used to partially fund the Aetna Acquisition and (ii) adjusting the amortized cost of Aetna's investment portfolio to fair value as of the completion of the Aetna Acquisition;
- Elimination of historical intangible asset, deferred acquisition cost and capitalized software amortization expense and addition of amortization expense based on the values of identified intangible assets;
- Additional interest expense from (i) the long-term debt issued to partially fund the Aetna Acquisition and (ii) the amortization of the fair value adjustment to assumed long-term debt.
- Additional depreciation expense related to the adjustment of Aetna's property and equipment to fair value;
- Adjustments to align CVS Health's and Aetna's accounting policies;
- Elimination of transaction related costs; and
- Tax effects of the adjustments noted above.

Divestiture of Workers' Compensation Business

On July 31, 2020, the Company sold its Workers' Compensation business for approximately $850 million. The results of this business have historically been reported within the Health Care Benefits segment. The Company recorded a pre-tax gain on the divestiture of $269 million in the year ended December 31, 2020, which is reflected as a reduction in operating expenses in the Company's consolidated statement of operations within the Health Care Benefits segment.

Divestiture of Brazilian Subsidiary

On July 1, 2019, the Company sold its Brazilian subsidiary, Onofre, for an immaterial amount. Onofre operated 50 retail pharmacy stores, the results of which historically had been reported within the Retail/LTC segment. The Company recorded a pre-tax loss on the divestiture of $205 million in the year ended December 31, 2019, which primarily relates to the elimination of the cumulative translation adjustment from accumulated other comprehensive income and is reflected in operating expenses in the Company's consolidated statement of operations within the Retail/LTC segment.

Divestiture of RxCrossroads Subsidiary

On January 2, 2018, the Company sold its RxCrossroads subsidiary, the results of which had historically been reported within the Retail/LTC segment, to McKesson Corporation for $725 million. The Company recorded a pre-tax loss on the divestiture of $86 million in the year ended December 31, 2018 which was reflected in operating expenses in the Company's consolidated statement of operations within the Retail/LTC segment.

3. Investments

Total investments at December 31, 2020 and 2019 were as follows:

	2020			2019		
In millions	**Current**	**Long-term**	**Total**	**Current**	**Long-term**	**Total**
Debt securities available for sale	$ 2,774	$ 18,414	$ 21,188	$ 2,251	$ 14,671	$ 16,922
Mortgage loans	226	821	1,047	122	1,091	1,213
Other investments	—	1,577	1,577	—	1,552	1,552
Total investments	$ 3,000	$ 20,812	$ 23,812	$ 2,373	$ 17,314	$ 19,687

At December 31, 2020 and 2019, the Company held investments of $524 million and $537 million, respectively, related to the 2012 conversion of an existing group annuity contract from a participating to a non-participating contract. The conversion occurred prior to the Aetna Acquisition. These investments are included in the total

investments of large case pensions supporting non-experience-rated products. Although these investments are not accounted for as Separate Accounts assets, they are legally segregated and are not subject to claims that arise out of the Company's business and only support future policy benefits obligations under that group annuity contract.

Debt Securities

Debt securities available for sale at December 31, 2020 and 2019 were as follows:

In millions	Amortized Cost [1]	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2020				
Debt securities:				
U.S. government securities	$ 2,341	$ 128	$ —	$ 2,469
States, municipalities and political subdivisions	2,556	172	—	2,728
U.S. corporate securities	7,879	1,023	(8)	8,894
Foreign securities	2,595	324	(1)	2,918
Residential mortgage-backed securities	673	32	—	705
Commercial mortgage-backed securities	962	84	—	1,046
Other asset-backed securities	2,369	36	(2)	2,403
Redeemable preferred securities	21	4	—	25
Total debt securities [2]	$ 19,396	$ 1,803	$ (11)	$ 21,188
December 31, 2019				
Debt securities:				
U.S. government securities	$ 1,791	$ 62	$ (1)	$ 1,852
States, municipalities and political subdivisions	2,202	108	(1)	2,309
U.S. corporate securities	7,167	573	(3)	7,737
Foreign securities	2,149	200	(1)	2,348
Residential mortgage-backed securities	508	25	—	533
Commercial mortgage-backed securities	654	46	—	700
Other asset-backed securities	1,397	13	(5)	1,405
Redeemable preferred securities	30	8	—	38
Total debt securities [2]	$ 15,898	$ 1,035	$ (11)	$ 16,922

(1) Effective January 1, 2020, the Company adopted the available-for-sale debt security impairment model under ASU 2016-13, *Financial Instruments -Credit Losses* (Topic 326). The new impairment model requires the write down of amortized cost through an allowance for credit losses, rather than through a reduction of the amortized cost basis of the available-for-sale debt security. There was no allowance for credit losses recorded on available-for-sale debt securities at December 31, 2020. As the Company adopted the new available-for-sale debt security impairment model on a prospective basis, there was no allowance for credit losses recorded on available-for-sale debt securities at December 31, 2019.

(2) Investment risks associated with the Company's experience-rated products generally do not impact the Company's consolidated operating results. At December 31, 2020, debt securities with a fair value of $919 million, gross unrealized capital gains of $135 million and no gross unrealized capital losses and at December 31, 2019, debt securities with a fair value of $965 million, gross unrealized capital gains of $83 million and no gross unrealized capital losses were included in total debt securities, but support experience-rated products. Changes in net unrealized capital gains (losses) on these securities are not reflected in accumulated other comprehensive income.

The amortized cost and fair value of debt securities at December 31, 2020 are shown below by contractual maturity. Actual maturities may differ from contractual maturities because securities may be restructured, called or prepaid, or the Company intends to sell a security prior to maturity.

In millions	**Amortized Cost**	**Fair Value**
Due to mature:		
Less than one year	$ 1,276	$ 1,291
One year through five years	6,346	6,698
After five years through ten years	3,748	4,121
Greater than ten years	4,022	4,924
Residential mortgage-backed securities	673	705
Commercial mortgage-backed securities	962	1,046
Other asset-backed securities	2,369	2,403
Total	$ 19,396	$ 21,188

Mortgage-Backed and Other Asset-Backed Securities
All of the Company's residential mortgage-backed securities at December 31, 2020 were issued by the Government National Mortgage Association, the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation and carry agency guarantees and explicit or implicit guarantees by the U.S. Government. At December 31, 2020, the Company's residential mortgage-backed securities had an average credit quality rating of AAA and a weighted average duration of 2.4 years.

The Company's commercial mortgage-backed securities have underlying loans that are dispersed throughout the United States. Significant market observable inputs used to value these securities include loss severity and probability of default. At December 31, 2020, these securities had an average credit quality rating of AAA and a weighted average duration of 6.1 years.

The Company's other asset-backed securities have a variety of underlying collateral (e.g., automobile loans, credit card receivables, home equity loans and commercial loans). Significant market observable inputs used to value these securities include the unemployment rate, loss severity and probability of default. At December 31, 2020, these securities had an average credit quality rating of AA and a weighted average duration of 1.1 years.

Summarized below are the debt securities the Company held at December 31, 2020 and 2019 that were in an unrealized capital loss position, aggregated by the length of time the investments have been in that position:

	Less than 12 months			Greater than 12 months			Total		
In millions, except number of securities	**Number of Securities**	**Fair Value**	**Unrealized Losses**	**Number of Securities**	**Fair Value**	**Unrealized Losses**	**Number of Securities**	**Fair Value**	**Unrealized Losses**
December 31, 2020									
Debt securities:									
U.S. government securities	32	$ 205	$ —	—	$ —	$ —	32	$ 205	$ —
States, municipalities and political subdivisions	49	83	—	—	—	—	49	83	—
U.S. corporate securities	145	155	8	2	—	—	147	155	8
Foreign securities	41	69	1	5	5	—	46	74	1
Residential mortgage-backed securities	23	26	—	3	—	—	26	26	—
Commercial mortgage-backed securities	22	75	—	—	—	—	22	75	—
Other asset-backed securities	156	256	1	49	41	1	205	297	2
Total debt securities	468	$ 869	$ 10	59	$ 46	$ 1	527	$ 915	$ 11
December 31, 2019									
Debt securities:									
U.S. government securities	52	$ 168	$ 1	—	$ —	$ —	52	$ 168	$ 1
States, municipalities and political subdivisions	66	115	1	2	5	—	68	120	1
U.S. corporate securities	181	305	2	2	—	1	183	305	3
Foreign securities	39	75	1	—	—	—	39	75	1
Residential mortgage-backed securities	30	16	—	9	—	—	39	16	—
Commercial mortgage-backed securities	16	49	—	—	—	—	16	49	—
Other asset-backed securities	138	254	1	187	182	4	325	436	5
Total debt securities	522	$ 982	$ 6	200	$ 187	$ 5	722	$ 1,169	$ 11

The Company reviewed the securities in the table above and concluded that they are performing assets generating investment income to support the needs of the Company's business. In performing this review, the Company considered factors such as the quality of the investment security based on research performed by the Company's internal credit analysts and external rating agencies and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. As of December 31, 2020, the Company did not intend to sell these securities, and did not believe it was more likely than not that it would be required to sell these securities prior to the anticipated recovery of their amortized cost basis.

The maturity dates for debt securities in an unrealized capital loss position at December 31, 2020 were as follows:

	Supporting experience-rated products		Supporting remaining products		Total	
In millions	**Fair Value**	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**
Due to mature:						
Less than one year	$ —	$ —	$ 9	$ —	$ 9	$ —
One year through five years	—	—	300	4	300	4
After five years through ten years	4	—	165	4	169	4
Greater than ten years	3	—	36	1	39	1
Residential mortgage-backed securities	—	—	26	—	26	—
Commercial mortgage-backed securities	2	—	73	—	75	—
Other asset-backed securities	5	—	292	2	297	2
Total	$ 14	$ —	$ 901	$ 11	$ 915	$ 11

Mortgage Loans

The Company's mortgage loans are collateralized by commercial real estate. During the years ended December 31, 2020 and 2019, the Company had the following activity in its mortgage loan portfolio:

In millions	**2020**	**2019**
New mortgage loans	$ 63	$ 131
Mortgage loans fully repaid	187	234
Mortgage loans foreclosed	—	—

The Company assesses mortgage loans on a regular basis for credit impairments, and assigns a credit quality indicator to each loan. The Company's credit quality indicator is internally developed and categorizes each loan in its portfolio on a scale from 1 to 7. These indicators are based upon several factors, including current loan-to-value ratios, current and future property cash flow, property condition, market trends, creditworthiness of the borrower and deal structure.

- *Category 1* - Represents loans of superior quality.
- *Categories 2 to 4* - Represent loans where credit risk is minimal to acceptable; however, these loans may display some susceptibility to economic changes.
- *Categories 5 and 6* - Represent loans where credit risk is not substantial, but these loans warrant management's close attention.
- *Category 7* - Represents loans where collections are potentially at risk; if necessary, an impairment is recorded.

Based upon the Company's assessments at December 31, 2020 and 2019, the amortized cost basis of the Company's mortgage loans within each credit quality indicator by year of origination was as follows:

	Amortized Cost Basis by Year of Origination						
In millions, except credit quality indicator	**2020**	**2019**	**2018**	**2017**	**2016**	**Prior**	**Total**
December 31, 2020							
1	$ —	$ —	$ —	$ 22	$ —	$ 37	$ 59
2 to 4	46	96	91	124	101	494	952
5 and 6	—	—	3	4	—	29	36
7	—	—	—	—	—	—	—
Total	$ 46	$ 96	$ 94	$ 150	$ 101	$ 560	$ 1,047
December 31, 2019							
1		$ —	$ —	$ 15	$ —	$ 43	$ 58
2 to 4		93	93	206	140	611	1,143
5 and 6		—	—	—	—	12	12
7		—	—	—	—	—	—
Total		$ 93	$ 93	$ 221	$ 140	$ 666	$ 1,213

At December 31, 2020 scheduled mortgage loan principal repayments were as follows:

In millions	
2021	$ 226
2022	147
2023	121
2024	172
2025	93
Thereafter	288
Total	$ 1,047

Net Investment Income

Sources of net investment income for the years ended December 31, 2020, 2019 and 2018 were as follows:

In millions	**2020**	**2019**	**2018**
Debt securities	$ 598	$ 589	$ 61
Mortgage loans	60	71	6
Other investments	123	194	593
Gross investment income	781	854	660
Investment expenses	(35)	(42)	(3)
Net investment income (excluding net realized capital gains or losses)	746	812	657
Net realized capital gains [(1)]	52	199	3
Net investment income [(2)]	$ 798	$ 1,011	$ 660

(1) Net realized capital gains are net of yield-related impairment losses on debt securities of $49 million for the year ended December 31, 2020. There were no credit-related losses on debt securities in the year ended December 31, 2020. Net realized capital gains are net of other-than-temporary impairment ("OTTI") losses on debt securities of $24 million for the year ended December 31, 2019. There were no material OTTI losses on debt securities for the year ended December 31, 2018.

(2) Net investment income includes $42 million, $44 million and $4 million for the years ended December 31, 2020, 2019 and 2018, respectively, related to investments supporting experience-rated products.

Capital gains and losses recognized during the year ended December 31, 2020 related to investments in equity securities held as of December 31, 2020 were not material.

Excluding amounts related to experience-rated products, proceeds from the sale of available for sale debt securities and the related gross realized capital gains and losses in the years ended December 31, 2020, 2019 and subsequent to the Aetna Acquisition Date in 2018 were as follows:

In millions	**2020**	**2019**	**2018**
Proceeds from sales	$ 3,913	$ 4,773	$ 389
Gross realized capital gains	80	146	2
Gross realized capital losses	62	17	2

4. Fair Value

The preparation of the Company's consolidated financial statements in accordance with GAAP requires certain assets and liabilities to be reflected at their fair value and others to be reflected on another basis, such as an adjusted historical cost basis. In this note, the Company provides details on the fair value of financial assets and liabilities and how it determines those fair values. The Company presents this information for those financial instruments that are measured at fair value for which the change in fair value impacts net income (loss) attributable to CVS Health or other comprehensive income separately from other financial assets and liabilities.

Financial Instruments Measured at Fair Value on the Consolidated Balance Sheets

Certain of the Company's financial instruments are measured at fair value on the consolidated balance sheets. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by GAAP. The following are the levels of the hierarchy and a brief description of the type of valuation information ("valuation inputs") that qualifies a financial asset or liability for each level:

- Level 1 – Unadjusted quoted prices for identical assets or liabilities in active markets.
- Level 2 – Valuation inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, valuation inputs that are observable that are not prices (such as interest rates and credit risks) and valuation inputs that are derived from or corroborated by observable markets.
- Level 3 – Developed from unobservable data, reflecting the Company's assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, the Company uses these quoted market prices to determine the fair value of financial assets and liabilities and classifies these assets and liabilities in Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, the Company estimates fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities are classified in Level 2. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The following is a description of the valuation methodologies used for the Company's financial assets and liabilities that are measured at fair value, including the general classification of such assets and liabilities pursuant to the valuation hierarchy.

Cash and Cash Equivalents – The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. When quoted prices are available in an active market, cash equivalents are classified in Level 1 of the fair value hierarchy. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt Securities – Where quoted prices are available in an active market, debt securities are classified in Level 1 of the fair value hierarchy. The Company's Level 1 debt securities consist primarily of U.S. Treasury securities.

The fair values of the Company's Level 2 debt securities are obtained using models, such as matrix pricing, which use quoted market prices of debt securities with similar characteristics or discounted cash flows to estimate fair value. The Company reviews these prices to ensure they are based on observable market inputs that include quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets and inputs that are observable that are not prices (such as interest rates and credit risks). The Company also reviews the methodologies and the assumptions used to calculate prices from these observable inputs. On a quarterly basis, the Company selects a sample of its Level 2 debt securities' prices and compares them to prices provided by a secondary source. Variances over a specified threshold are identified and reviewed to confirm the price provided by the primary source represents an appropriate estimate of fair value. In addition, the Company's internal investment team consistently compares the prices obtained for select Level 2 debt securities to the team's own independent estimates of fair value for those securities. The Company obtained one price for each of its Level 2 debt securities and did not adjust any of those prices at December 31, 2020 or 2019.

The Company also values certain debt securities using Level 3 inputs. For Level 3 debt securities, fair values are determined by outside brokers or, in the case of certain private placement securities, are priced internally. Outside brokers determine the value of these debt securities through a combination of their knowledge of the current pricing environment and market flows. The Company did not have any broker quoted debt securities for the years ended December 31, 2020 and 2019. For some private placement securities, the Company's internal staff determines the value of these debt securities by analyzing spreads of corporate and sector indices as well as interest spreads of comparable public bonds. Examples of these private placement Level 3 debt securities include certain U.S. and foreign securities and certain tax-exempt municipal securities.

Equity Securities – The Company currently has two classifications of equity securities: those that are publicly traded and those that are privately placed. Publicly-traded equity securities are classified in Level 1 because quoted prices are available for these securities in an active market. For privately placed equity securities, there is no active market; therefore, these securities are classified in Level 3 because the Company prices these securities through an internal analysis of each investment's financial statements and cash flow projections. Significant unobservable inputs consist of earnings and revenue multiples, discount for lack of marketability and comparability adjustments. An increase or decrease in any of these unobservable inputs would have resulted in a change in the fair value measurement.

There were no financial liabilities measured at fair value on a recurring basis on the consolidated balance sheets at December 31, 2020 or 2019. Financial assets measured at fair value on a recurring basis on the consolidated balance sheets at December 31, 2020 and 2019 were as follows:

In millions	**Level 1**	**Level 2**	**Level 3**	**Total**
December 31, 2020				
Cash and cash equivalents	$ 4,210	$ 3,869	$ —	$ 8,079
Debt securities:				
U.S. government securities	2,370	99	—	2,469
States, municipalities and political subdivisions	—	2,727	1	2,728
U.S. corporate securities	—	8,842	52	8,894
Foreign securities	—	2,918	—	2,918
Residential mortgage-backed securities	—	705	—	705
Commercial mortgage-backed securities	—	1,046	—	1,046
Other asset-backed securities	—	2,403	—	2,403
Redeemable preferred securities	—	24	1	25
Total debt securities	2,370	18,764	54	21,188
Equity securities	17	—	30	47
Total	$ 6,597	$ 22,633	$ 84	$ 29,314
December 31, 2019				
Cash and cash equivalents	$ 3,397	$ 2,286	$ —	$ 5,683
Debt securities:				
U.S. government securities	1,785	67	—	1,852
States, municipalities and political subdivisions	—	2,309	—	2,309
U.S. corporate securities	—	7,700	37	7,737
Foreign securities	—	2,348	—	2,348
Residential mortgage-backed securities	—	533	—	533
Commercial mortgage-backed securities	—	700	—	700
Other asset-backed securities	—	1,405	—	1,405
Redeemable preferred securities	—	26	12	38
Total debt securities	1,785	15,088	49	16,922
Equity securities	34	—	39	73
Total	$ 5,216	$ 17,374	$ 88	$ 22,678

The changes in the balances of Level 3 financial assets during the year ended December 31, 2020 were as follows:

In millions	States, municipalities and political subdivisions	U.S. corporate securities	Equity securities	Redeemable preferred securities	Total
Beginning balance	$ —	$ 37	$ 39	$ 12	$ 88
Net realized and unrealized capital gains (losses):					
Included in earnings	—	(11)	(3)	18	4
Included in other comprehensive income	—	—	—	(5)	(5)
Purchases	—	27	3	—	30
Sales	—	—	(9)	(24)	(33)
Settlements	—	(1)	—	—	(1)
Transfers into Level 3, net	1	—	—	—	1
Ending balance	$ 1	$ 52	$ 30	$ 1	$ 84

The change in unrealized capital losses included in other comprehensive income associated with Level 3 financial assets which were held as of December 31, 2020 was $4 million during the year ended December 31, 2020.

The changes in the balances of Level 3 financial assets during the year ended December 31, 2019 were as follows:

In millions	Foreign securities	U.S. corporate securities	Equity securities	Redeemable preferred securities	Total
Beginning balance	$ 3	$ 67	$ 54	$ 7	$ 131
Net realized and unrealized capital gains (losses):					
Included in earnings	—	(33)	13	—	(20)
Included in other comprehensive income	—	18	—	5	23
Purchases	2	3	13	—	18
Sales	—	(6)	(41)	—	(47)
Settlements	(1)	(12)	—	—	(13)
Transfers out of Level 3, net	(4)	—	—	—	(4)
Ending balance	$ —	$ 37	$ 39	$ 12	$ 88

The total gross transfers into (out of) Level 3 during the years ended December 31, 2020 and 2019 were as follows:

In millions	2020	2019
Gross transfers into Level 3	$ 1	$ —
Gross transfers out of Level 3	—	(4)
Net transfers out of Level 3	$ 1	$ (4)

Financial Instruments Not Measured at Fair Value on the Consolidated Balance Sheets

The carrying value and estimated fair value classified by level of fair value hierarchy for financial instruments carried on the consolidated balance sheets at adjusted cost or contract value at December 31, 2020 and 2019 were as follows:

		Estimated Fair Value			
In millions	**Carrying Value**	**Level 1**	**Level 2**	**Level 3**	**Total**
December 31, 2020					
Assets:					
Mortgage loans	$ 1,047	$ —	$ —	$ 1,070	$ 1,070
Equity securities [(1)]	145	N/A	N/A	N/A	N/A
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	5	—	—	5	5
Without a fixed maturity	322	—	—	371	371
Long-term debt	64,647	75,940	—	—	75,940
December 31, 2019					
Assets:					
Mortgage loans	$ 1,213	$ —	$ —	$ 1,239	$ 1,239
Equity securities [(1)]	149	N/A	N/A	N/A	N/A
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	5	—	—	5	5
Without a fixed maturity	372	—	—	392	392
Long-term debt	68,480	74,306	—	—	74,306

(1) It was not practical to estimate the fair value of these cost-method investments as it represents shares of unlisted companies. See Note 1 "Significant Accounting Policies" for additional information regarding the valuation of cost method investments.

Separate Accounts Measured at Fair Value on the Consolidated Balance Sheets

Separate Accounts assets relate to the Company's large case pensions products which represent funds maintained to meet specific objectives of contract holders. Since contract holders bear the investment risk of these assets, a corresponding Separate Accounts liability has been established equal to the assets. These assets and liabilities are carried at fair value. Net investment income and capital gains and losses on Separate Accounts assets accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from the Company's other businesses. Deposits, withdrawals, net investment income and realized and unrealized capital gains and losses on Separate Accounts assets are not reflected in the consolidated statements of operations, shareholders' equity or cash flows.

Separate Accounts assets include debt and equity securities. The valuation methodologies used for these assets are similar to the methodologies described above in this Note 4 "Fair Value." Separate Accounts assets also include investments in common/collective trusts that are carried at fair value. Common/collective trusts invest in other investment funds otherwise known as the underlying funds. The Separate Accounts' interests in the common/collective trust funds are based on the fair values of the investments of the underlying funds and therefore are classified in Level 2. The assets in the underlying funds primarily consist of equity securities. Investments in common/collective trust funds are valued at their respective net asset value ("NAV") per share/unit on the valuation date.

Separate Accounts financial assets at December 31, 2020 and 2019 were as follows:

	December 31, 2020				December 31, 2019			
In millions	**Level 1**	**Level 2**	**Level 3**	**Total**	**Level 1**	**Level 2**	**Level 3**	**Total**
Cash and cash equivalents	$ 2	$ 186	$ —	$ 188	$ 2	$ 143	$ —	$ 145
Debt securities	1,465	2,634	—	4,099	1,224	2,589	—	3,813
Equity securities	—	2	—	2	—	2	—	2
Common/collective trusts	—	563	—	563	—	499	—	499
Total [1]	$ 1,467	$ 3,385	$ —	$ 4,852	$ 1,226	$ 3,233	$ —	$ 4,459

(1) Excludes $29 million of other receivables at December 31, 2020.

During the years ended December 31, 2020 and 2019, the Company had no gross transfers of Separate Accounts financial assets into or out of Level 3.

Offsetting Financial Assets and Liabilities

Certain financial assets and liabilities are offset in the Company's consolidated balance sheets or are subject to master netting arrangements or similar agreements with the applicable counterparty. Financial assets subject to offsetting and enforceable master netting arrangements were $2 million as of December 31, 2020. Financial liabilities subject to offsetting and enforceable master netting arrangements were $3 million as of December 31, 2019.

5. Goodwill and Other Intangibles

Goodwill

Below is a summary of the changes in the carrying amount of goodwill by segment for the years ended December 31, 2020 and 2019:

In millions	**Pharmacy Services**	**Retail/ LTC**	**Health Care Benefits**	**Total**
Balance at December 31, 2018	$ 23,388	$ 10,806	$ 44,484	$ 78,678
Segment realignment	194	—	(194)	—
Purchase accounting adjustments	—	—	1,071	1,071
Other	(1)	1	—	—
Balance at December 31, 2019	23,581	10,807	45,361	79,749
Acquisitions	34	—	274	308
Divestiture of Workers' Compensation business	—	—	(505)	(505)
Balance at December 31, 2020	$ 23,615	$ 10,807	$ 45,130	$ 79,552

During the year ended December 31, 2020, the decrease in the carrying amount of goodwill was primarily driven by the divestiture of the Workers' Compensation business, partially offset by goodwill associated with immaterial acquisitions. During the year ended December 31, 2019, the increase in the carrying amount of goodwill was primarily driven by purchase accounting adjustments associated with the Aetna Acquisition. See Note 2 "Acquisitions and Divestitures" for further discussion regarding the Workers' Compensation business divestiture and the Aetna Acquisition.

During 2019, the Company also realigned the composition of its segments to correspond with changes to its operating model and to reflect how the Chief Operating Decision Maker (the "CODM") reviews information and manages the business. As a result of this realignment, the Company reallocated the associated goodwill balance to the Pharmacy Services and Health Care Benefits segments based on a relative fair value approach.

Goodwill Impairment

During the third quarter of both 2020 and 2019, the Company performed its required annual impairment tests of goodwill. The results of these impairment tests indicated that there was no impairment of goodwill. At both December 31, 2020 and 2019, cumulative goodwill impairments were $6.1 billion.

The LTC reporting unit has experienced industry-wide challenges that have impacted management's ability to grow the business at the rate that was originally estimated when the Company acquired Omnicare, Inc. ("Omnicare") in 2015. Those challenges include lower client retention rates, lower occupancy rates in skilled nursing facilities, the deteriorating financial health of numerous skilled nursing facility customers which resulted in a number of customer bankruptcies in 2018, and continued facility reimbursement pressures.

Following the update of its current and long-term forecasts in June 2018, management determined that there were indicators that the LTC reporting unit's goodwill may be impaired and, accordingly, management performed an interim goodwill impairment test as of June 30, 2018. The results of that interim impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in a $3.9 billion pre-tax goodwill impairment charge in the second quarter of 2018.

During the third quarter of 2018, the Company performed its required annual impairment tests of goodwill and concluded there was no impairment of goodwill or trade names.

During the fourth quarter of 2018, the LTC reporting unit missed its forecast primarily due to operational issues and customer liquidity issues, including one significant customer bankruptcy. Additionally, LTC management submitted updated projected financial results which showed significant additional deterioration primarily due to continued industry and operational challenges including lower occupancy rates in skilled nursing facilities, significant deterioration in the financial health of numerous skilled nursing facility customers and continued facility reimbursement pressures. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be further impaired and, accordingly, management performed an interim goodwill impairment test during the fourth quarter of 2018. The results of that interim impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in an additional $2.2 billion pre-tax goodwill impairment charge in the fourth quarter of 2018.

As of December 31, 2020, the remaining goodwill balance in the LTC reporting unit was $431 million.

Intangible Assets

The following table is a summary of the Company's intangible assets as of December 31, 2020 and 2019:

In millions, except weighted average life	**Gross Carrying Amount**	**Accumulated Amortization**	**Net Carrying Amount**	**Weighted Average Life (years)**
2020				
Trademarks (indefinite-lived)	$ 10,498	$ —	$ 10,498	N/A
Customer contracts/relationships and covenants not to compete	24,952	(8,923)	16,029	14.9
Technology	1,060	(739)	321	3.0
Provider networks	4,203	(440)	3,763	20.0
Value of Business Acquired	590	(119)	471	20.0
Other	320	(260)	60	7.7
Total	$ 41,623	$ (10,481)	$ 31,142	15.2
2019				
Trademarks (indefinite-lived)	$ 10,498	$ —	$ 10,498	N/A
Customer contracts/relationships and covenants not to compete	25,447	(8,128)	17,319	14.8
Technology	1,060	(386)	674	3.0
Provider networks	4,200	(229)	3,971	20.0
Value of Business Acquired	590	(63)	527	20.0
Other	364	(232)	132	8.1
Total	$ 42,159	$ (9,038)	$ 33,121	15.1

Amortization expense for intangible assets totaled $2.3 billion, $2.4 billion and $1.0 billion for the years ended December 31, 2020, 2019 and 2018, respectively. The projected annual amortization expense for the Company's intangible assets for the next five years is as follows:

In millions	
2021	$ 2,249
2022	1,842
2023	1,812
2024	1,770
2025	1,718

6. Leases

The Company adopted ASU 2016-02, *Leases* (Topic 842) ("ASC 842") on January 1, 2019 on a modified retrospective basis. As a result, the Company's lease disclosures as of and for the years ended December 31, 2020 and 2019 are reported under ASC 842. Comparative financial information for the year ended December 31, 2018 has not been restated and continues to be reported under ASC 840, the lease accounting standard in effect for that period.

Disclosure Subsequent to the Adoption of the New Lease Accounting Standard (ASU 2016-02)

The Company leases most of its retail stores and mail order facilities and certain distribution centers and corporate offices under operating or finance leases, typically with initial terms of 15 to 25 years. The Company also leases certain equipment and other assets under operating or finance leases, typically with initial terms of 3 to 10 years**.**

In addition, the Company leases pharmacy space at the stores of another retail chain for which the noncancelable contractual term of the pharmacy lease arrangement exceeds the remaining estimated economic life of the buildings. For these pharmacy lease arrangements, the Company concluded that for accounting purposes the lease term was the remaining estimated economic life of the buildings. Consequently, most of these individual pharmacy leases are finance leases.

The following table is a summary of the components of net lease cost for the years ended December 31, 2020 and 2019:

In millions	**2020**	**2019**
Operating lease cost	$ 2,670	$ 2,720
Finance lease cost:		
Amortization of right-of-use assets	56	38
Interest on lease liabilities	58	44
Total finance lease costs	114	82
Short-term lease costs	22	24
Variable lease costs	599	581
Less: sublease income	55	50
Net lease cost	$ 3,350	$ 3,357

Supplemental cash flow information related to leases for the years ended December 31, 2020 and 2019 is as follows:

In millions	**2020**	**2019**
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows paid for operating leases	$ 2,724	$ 2,701
Operating cash flows paid for interest portion of finance leases	58	44
Financing cash flows paid for principal portion of finance leases	34	26
Right-of-use assets obtained in exchange for lease obligations:		
Operating leases	1,679	1,824
Finance leases	313	283

Supplemental balance sheet information related to leases as of December 31, 2020 and 2019 is as follows:

In millions, except remaining lease term and discount rate	**2020**	**2019**
Operating leases:		
Operating lease right-of-use assets	$ 20,729	$ 20,860
Current portion of operating lease liabilities	$ 1,638	$ 1,596
Long-term operating lease liabilities	18,757	18,926
Total operating lease liabilities	$ 20,395	$ 20,522
Finance leases:		
Property and equipment, gross	$ 1,107	$ 790
Accumulated depreciation	(106)	(38)
Property and equipment, net	$ 1,001	$ 752
Current portion of long-term debt	$ 33	$ 27
Long-term debt	1,050	781
Total finance lease liabilities	$ 1,083	$ 808
Weighted average remaining lease term *(in years)*		
Operating leases	13.3	13.8
Finance leases	20.3	20.5
Weighted average discount rate		
Operating leases	4.5 %	4.6 %
Finance leases	5.6 %	6.7 %

The following table summarizes the maturity of lease liabilities under finance and operating leases as of December 31, 2020:

In millions	**Finance Leases**	**Operating Leases [1]**	**Total**
2021	$ 100	$ 2,688	$ 2,788
2022	98	2,583	2,681
2023	96	2,496	2,592
2024	95	2,269	2,364
2025	95	2,089	2,184
Thereafter	1,328	15,017	16,345
Total lease payments [2]	1,812	27,142	28,954
Less: imputed interest	(729)	(6,747)	(7,476)
Total lease liabilities	$ 1,083	$ 20,395	$ 21,478

(1) Future operating lease payments have not been reduced by minimum sublease rentals of $306 million due in the future under noncancelable subleases.

(2) The Company leases pharmacy and clinic space from Target Corporation. Amounts related to such finance and operating leases are reflected above. Pharmacy lease amounts due in excess of the remaining estimated economic life of the buildings of approximately $2.3 billion are not reflected in this table since the estimated economic life of the buildings is shorter than the contractual term of the pharmacy lease arrangement.

Sale-Leaseback Transactions

The Company finances a portion of its store development program through sale-leaseback transactions. The properties are generally sold at net book value, which generally approximates fair value, and the resulting leases generally qualify and are accounted for as operating leases. The operating leases that resulted from these transactions are included in the tables above.

The Company does not have any retained or contingent interests in the stores and does not provide any guarantees, other than a guarantee of lease payments, in connection with the sale-leaseback transactions. Proceeds from sale-leaseback transactions totaled $101 million and $5 million in the years ended December 31, 2020 and 2019, respectively. Gains from sale-leaseback transactions totaled $3 million in the year ended December 31, 2020. There were no material gains from sale-leaseback transactions in the year ended December 31, 2019.

Store Rationalization Charges
During the first quarter of 2019, the Company performed a review of its retail stores and determined it would close 46 underperforming retail pharmacy stores during the second quarter of 2019. As a result, management determined that there were indicators of impairment with respect to the impacted stores, including the associated operating lease right-of-use assets. Accordingly, an interim long-lived asset impairment test was performed. The results of the impairment test indicated that the fair value of each store asset group was lower than the carrying value. The fair value was determined using a discounted cash flow method based on estimated sublease income. In the three months ended March 31, 2019, the Company recorded a store rationalization charge of $135 million, primarily related to these operating lease right-of-use asset impairment charges, which was recorded within operating expenses in the Retail/LTC segment.

During the third quarter of 2019, in connection with its annual budgeting process, the Company performed an updated review of its retail stores and determined it would close an additional 22 underperforming retail pharmacy stores during the first quarter of 2020. As a result, management determined that there were indicators of impairment with respect to the impacted stores, including the associated operating lease right-of-use assets. Accordingly, an interim long-lived asset impairment test was performed. The results of the impairment test indicated that the fair value of each store asset group was lower than the carrying value. The fair value was determined using a discounted cash flow method based on estimated sublease income. In the three months ended September 30, 2019, the Company recorded a store rationalization charge of $96 million, primarily related to these operating lease right-of-use asset impairment charges, which was recorded within operating expenses in the Retail/LTC segment.

Comparative Disclosure Prior to the Adoption of the New Lease Accounting Standard (ASU 2016-02)

The following table is a summary of the Company's net rental expense for operating leases for the year ended December 31, 2018:

In millions	**2018**
Minimum rentals	$ 2,528
Contingent rentals	28
Rental expense	2,556
Less: sublease income	(21)
Total rental expense, net	$ 2,535

7. Health Care Costs Payable

The following is information about incurred and cumulative paid health care claims development as of December 31, 2020, net of reinsurance, and the total IBNR liabilities plus expected development on reported claims included within the net incurred claims amounts. See Note 1 ‘‘Significant Accounting Policies’’ for information on how the Company estimates IBNR reserves and health care costs payable as well as changes to those methodologies, if any. The Company’s estimate of IBNR liabilities is primarily based on trend and completion factors. Claim frequency is not used in the calculation of the Company’s liability. In addition, it is impracticable to disclose claim frequency information for health care claims due to the Company’s inability to gather consistent claim frequency information across its multiple claims processing systems. Any claim frequency count disclosure would not be comparable across the Company’s different claim processing systems and would not be consistent from period to period based on the volume of claims processed through each system. As a result, health care claim count frequency is not included in the disclosures below.

The information about incurred and paid health care claims development for the year ended December 31, 2019 is presented as required unaudited supplemental information.

In millions	**Incurred Health Care Claims, Net of Reinsurance For the Years Ended December 31,**	
Date of Service	**2019**	**2020**
	(Unaudited)	
2019	$ 51,426	$ 51,056
2020		54,529
	Total	$ 105,585

In millions	**Cumulative Paid Health Care Claims, Net of Reinsurance For the Years Ended December 31,**	
Date of Service	**2019**	**2020**
	(Unaudited)	
2019	$ 44,987	$ 50,394
2020		47,567
	Total	$ 97,961
All outstanding liabilities for health care costs payable prior to 2019, net of reinsurance		144
Total outstanding liabilities for health care costs payable, net of reinsurance		$ 7,768

At December 31, 2020, the Company’s liabilities for IBNR plus expected development on reported claims totaled approximately $6.1 billion. Substantially all of the Company’s liabilities for IBNR plus expected development on reported claims at December 31, 2020 related to the current calendar year.

The reconciliation of the December 31, 2020 health care net incurred and paid claims development tables to the health care costs payable liability on the consolidated balance sheet is as follows:

In millions	**December 31, 2020**
Short-duration health care costs payable, net of reinsurance	$ 7,768
Reinsurance recoverables	10
Premium deficiency reserve	11
Insurance lines other than short duration	147
Total health care costs payable	$ 7,936

Prior to the Aetna Acquisition on November 28, 2018, the Company's health care costs payable balance was immaterial and related to unpaid pharmacy claims for its SilverScript PDP. The following table shows the components of the change in health care costs payable during the years ended December 31, 2020, 2019 and 2018:

In millions	**2020**	**2019**	**2018**
Health care costs payable, beginning of period	$ 6,879	$ 6,147	$ 5
Less: Reinsurance recoverables	5	4	—
Health care costs payable, beginning of period, net	6,874	6,143	5
Acquisitions, net	414	—	5,357
Reclassification from pharmacy claims and discounts payable [1]	—	—	776
Add: Components of incurred health care costs			
Current year	55,835	52,723	6,594
Prior years	(429)	(524)	(42)
Total incurred health care costs [2]	55,406	52,199	6,552
Less: Claims paid			
Current year	48,770	46,158	6,303
Prior years	6,009	5,314	260
Total claims paid	54,779	51,472	6,563
Add: Premium deficiency reserve	11	4	16
Health care costs payable, end of period, net	7,926	6,874	6,143
Add: Reinsurance recoverables	10	5	4
Health care costs payable, end of period	$ 7,936	$ 6,879	$ 6,147

(1) As of the Aetna Acquisition Date, the Company reclassified $776 million of the Pharmacy Services segment's unpaid retail pharmacy claims to third parties from pharmacy claims and discounts payable to health care costs payable as the third party liability was incurred to support the Health Care Benefits segment's insured members.

(2) Total incurred health care costs for the years ended December 31, 2020, 2019 and 2018 in the table above exclude (i) $11 million, $4 million and $16 million, respectively, for a premium deficiency reserve related to the Company's Medicaid products, (ii) $41 million, $41 million and $4 million, respectively, of benefit costs recorded in the Health Care Benefits segment that are included in other insurance liabilities on the consolidated balance sheets and (iii) $221 million, $285 million and $22 million, respectively, of benefit costs recorded in the Corporate/Other segment that are included in other insurance liabilities on the consolidated balance sheets.

The Company's estimates of prior years' health care costs payable decreased by $429 million and $524 million in 2020 and 2019, respectively, because claims were settled for amounts less than originally estimated (i.e., the amount of claims incurred was lower than originally estimated), primarily due to lower health care cost trends as well as the actual claim submission time being faster than originally assumed (i.e., the Company's completion factors were higher than originally assumed) in estimating health care costs payable at the end of the prior year. This development does not directly correspond to an increase in the Company's operating results as these reductions were offset by estimated current period health care costs when the Company established the estimate of the current year health care costs payable.

8. Borrowings and Credit Agreements

The following table is a summary of the Company's borrowings as of December 31, 2020 and 2019:

In millions	2020	2019
Long-term debt		
3.125% senior notes due March 2020	$ —	$ 723
Floating rate notes due March 2020 (2.515% at December 31, 2019)	—	277
2.8% senior notes due July 2020	—	2,750
3.35% senior notes due March 2021	2,038	2,038
Floating rate notes due March 2021 (0.950% and 2.605% at December 31, 2020 and 2019, respectively)	1,000	1,000
4.125% senior notes due May 2021	222	222
2.125% senior notes due June 2021	1,750	1,750
4.125% senior notes due June 2021	203	203
5.45% senior notes due June 2021	187	187
3.5% senior notes due July 2022	1,500	1,500
2.75% senior notes due November 2022	1,000	1,000
2.75% senior notes due December 2022	1,250	1,250
4.75% senior notes due December 2022	399	399
3.7% senior notes due March 2023	2,336	6,000
2.8% senior notes due June 2023	1,300	1,300
4% senior notes due December 2023	414	1,250
3.375% senior notes due August 2024	650	650
2.625% senior notes due August 2024	1,000	1,000
3.5% senior notes due November 2024	750	750
5% senior notes due December 2024	299	299
4.1% senior notes due March 2025	950	5,000
3.875% senior notes due July 2025	2,828	2,828
2.875% senior notes due June 2026	1,750	1,750
3% senior notes due August 2026	750	750
3.625% senior notes due April 2027	750	—
6.25% senior notes due June 2027	372	372
1.3% senior notes due August 2027	2,250	—
4.3% senior notes due March 2028	7,050	9,000
3.25% senior notes due August 2029	1,750	1,750
3.75% senior notes due April 2030	1,500	—
1.75% senior notes due August 2030	1,250	—
1.875% senior notes due February 2031	1,250	—
4.875% senior notes due July 2035	652	652
6.625% senior notes due June 2036	771	771
6.75% senior notes due December 2037	533	533
4.78% senior notes due March 2038	5,000	5,000
6.125% senior notes due September 2039	447	447
4.125% senior notes due April 2040	1,000	—
2.7% senior notes due August 2040	1,250	—
5.75% senior notes due May 2041	133	133
4.5% senior notes due May 2042	500	500
4.125% senior notes due November 2042	500	500
5.3% senior notes due December 2043	750	750
4.75% senior notes due March 2044	375	375
5.125% senior notes due July 2045	3,500	3,500
3.875% senior notes due August 2047	1,000	1,000
5.05% senior notes due March 2048	8,000	8,000
4.25% senior notes due April 2050	750	—
Finance lease liabilities	1,083	808
Other	326	279
Total debt principal	65,318	69,246
Debt premiums	238	262
Debt discounts and deferred financing costs	(909)	(1,028)
	64,647	68,480

The following is a summary of the Company's required repayments of debt principal due during each of the next five years and thereafter, as of December 31, 2020:

In millions	
2021	$ 5,405
2022	4,154
2023	4,055
2024	2,706
2025	3,785
Thereafter	44,130
Total	64,235
Finance lease liabilities [(1)]	1,083
Total debt principal	$ 65,318

(1) See Note 6 "Leases" for a summary of maturities of the Company's finance lease liabilities.

Short-term Borrowings

Commercial Paper and Back-up Credit Facilities
The Company did not have any commercial paper outstanding as of December 31, 2020 or 2019. In connection with its commercial paper program, the Company maintains a $1.0 billion 364-day unsecured back-up revolving credit facility, which expires on May 12, 2021, a $1.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 18, 2022, a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 17, 2023 and a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 16, 2024. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately 0.03%, regardless of usage. As of December 31, 2020 and 2019, there were no borrowings outstanding under any of the Company's back-up credit facilities.

Federal Home Loan Bank of Boston ("FHLBB")
Since the Aetna Acquisition Date, a subsidiary of the Company is a member of the FHLBB. As a member, the subsidiary has the ability to obtain cash advances, subject to certain minimum collateral requirements. The maximum borrowing capacity available from the FHLBB as of December 31, 2020 was approximately $925 million. At both December 31, 2020 and 2019, there were no outstanding advances from the FHLBB.

Long-term Borrowings

2020 Notes
On December 16, 2020, the Company issued $750 million aggregate principal amount of 1.3% unsecured senior notes due August 21, 2027 and $1.25 billion aggregate principal amount of 1.875% unsecured senior notes due February 28, 2031 for total proceeds of approximately $1.99 billion, net of discounts and underwriting fees. The $750 million aggregate principal amount of 1.3% unsecured senior notes represent a further issuance of the Company's 1.3% unsecured senior notes due August 21, 2027 initially issued in an aggregate principal amount of $1.5 billion on August 21, 2020.

On August 21, 2020, the Company issued $1.5 billion aggregate principal amount of 1.3% unsecured senior notes due August 21, 2027, $1.25 billion aggregate principal amount of 1.75% unsecured senior notes due August 21, 2030 and $1.25 billion aggregate principal amount of 2.7% unsecured senior notes due August 21, 2040 (collectively, the "August 2020 Notes") for total proceeds of approximately $3.97 billion, net of discounts and underwriting fees.

On March 31, 2020, the Company issued $750 million aggregate principal amount of 3.625% unsecured senior notes due April 1, 2027, $1.5 billion aggregate principal amount of 3.75% unsecured senior notes due April 1, 2030, $1.0 billion aggregate principal amount of 4.125% unsecured senior notes due April 1, 2040 and $750 million aggregate principal amount of 4.25% unsecured senior notes due April 1, 2050 (collectively, the "March 2020 Notes") for total proceeds of approximately $3.95 billion, net of discounts and underwriting fees.

The net proceeds of these offerings were used for general corporate purposes, which may include working capital, capital expenditures, as well as the repurchase and/or repayment of indebtedness.

During March 2020, the Company entered into several interest rate swap transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of the March 2020 Notes. In connection with the issuance of the March 2020 Notes, the Company terminated all outstanding cash flow hedges. The Company paid a net amount of $7 million to the hedge counterparties upon termination, which was recorded as a loss, net of tax, of $5 million in accumulated other comprehensive income and will be reclassified as interest expense over the life of the March 2020 Notes. See Note 13 "Other Comprehensive Income" for additional information.

2019 Notes

On August 15, 2019, the Company issued $1.0 billion aggregate principal amount of 2.625% unsecured senior notes due August 15, 2024, $750 million aggregate principal amount of 3% unsecured senior notes due August 15, 2026 and $1.75 billion aggregate principal amount of 3.25% unsecured senior notes due August 15, 2029 (collectively, the "2019 Notes") for total proceeds of approximately $3.46 billion, net of discounts and underwriting fees. The net proceeds of the 2019 Notes were used to repay certain of the Company's outstanding debt.

Beginning in July 2019, the Company entered into several interest rate swap and treasury lock transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of the 2019 Notes. In connection with the issuance of the 2019 Notes, the Company terminated all outstanding cash flow hedges. The Company paid a net amount of $25 million to the hedge counterparties upon termination, which was recorded as a loss, net of tax, of $18 million in accumulated other comprehensive income and will be reclassified as interest expense over the life of the 2019 Notes. See Note 13 "Other Comprehensive Income" for additional information.

Early Extinguishments of Debt

In December 2020, the Company purchased $4.5 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $113 million of its 4.0% senior notes due 2023, $1.4 billion of its 3.7% senior notes due 2023, $1.0 billion of its 4.1% senior notes due 2025 and $2.0 billion of its 4.3% senior notes due 2028. In connection with the purchase of such senior notes, the Company paid a premium of $619 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $45 million of unamortized deferred financing costs and incurred $10 million in fees, for a total loss on early extinguishment of debt of $674 million.

In August 2020, the Company purchased $6.0 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $723 million of its 4.0% senior notes due 2023, $2.3 billion of its 3.7% senior notes due 2023 and $3.0 billion of its 4.1% senior notes due 2025. In connection with the purchase of such senior notes, the Company paid a premium of $706 million in excess of the aggregate principal amount of the senior notes that were purchased, wrote-off $47 million of unamortized deferred financing costs and incurred $13 million in fees, for a total loss on early extinguishment of debt of $766 million.

In August 2019, the Company purchased $4.0 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $1.3 billion of its 3.125% senior notes due 2020, $723 million of its floating rate notes due 2020, $328 million of its 4.125% senior notes due 2021, $297 million of 4.125% senior notes due 2021 issued by Aetna, $413 million of 5.45% senior notes due 2021 issued by Coventry Health Care, Inc., a wholly-owned subsidiary of Aetna, and $962 million of its 3.35% senior notes due 2021. In connection with the purchase of such senior notes, the Company paid a premium of $76 million in excess of the aggregate principal amount of the senior notes that were purchased, incurred $8 million in fees and recognized a net gain of $5 million on the write-off of net unamortized deferred financing premiums, for a net loss on early extinguishment of debt of $79 million.

Debt Covenants

The Company's back-up revolving credit facilities, unsecured senior notes and unsecured floating rate notes contain customary restrictive financial and operating covenants. These covenants do not include an acceleration of the Company's debt maturities in the event of a downgrade in the Company's credit ratings. The Company does not believe the restrictions contained in these covenants materially affect its financial or operating flexibility. As of December 31, 2020, the Company was in compliance with all of its debt covenants.

9. Pension Plans and Other Postretirement Benefits

Defined Contribution Plans

As of December 31, 2020, the Company sponsors several active 401(k) savings plans that cover all employees who meet plan eligibility requirements.

The Company makes matching contributions consistent with the provisions of the respective plans. At the participant's option, account balances, including the Company's matching contribution, can be invested among various investment options under each plan. The CVS Health Future Fund 401(k) Plan offers the Company's common stock fund as an investment option. The Company also maintains nonqualified, unfunded deferred compensation plans for certain key employees. The plans provide participants the opportunity to defer portions of their eligible compensation and for certain nonqualified plans, participants receive matching contributions equivalent to what they could have received under the CVS Health Future Fund 401(k) Plan absent certain restrictions and limitations under the Internal Revenue Code. The Company's contributions under its defined contribution plans were $520 million, $550 million and $334 million in the years ended December 31, 2020, 2019 and 2018, respectively. The Company's contributions for the years ended December 31, 2019 and 2018 include contributions to the Aetna 401(k) Plan subsequent to the Aetna Acquisition Date. On January 1, 2020, the Aetna 401(k) Plan was merged into the CVS Health Future Fund 401(k) Plan.

Defined Benefit Pension Plans

On November 28, 2018, the Company completed the Aetna Acquisition. Aetna sponsors a tax-qualified defined benefit pension plan that was frozen in 2010. Aetna also sponsors a nonqualified supplemental pension plan that was frozen in 2007. Aetna's pension plan benefit obligations and the fair value of plan assets were remeasured as of the Aetna Acquisition Date. The Company also sponsors several other defined benefit pension plans that are unfunded nonqualified supplemental retirement plans.

Pension Benefit Obligation and Plan Assets
The following tables outline the change in pension benefit obligation and plan assets over the specified periods:

In millions	**2020**	**2019**
Change in benefit obligation:		
Benefit obligation, beginning of year	$ 6,239	$ 5,841
Interest cost	168	225
Actuarial loss	413	530
Benefit payments	(358)	(357)
Benefit obligation, end of year	6,462	6,239
Change in plan assets:		
Fair value of plan assets, beginning of year	6,395	5,663
Actual return on plan assets	783	1,064
Employer contributions	25	25
Benefit payments	(358)	(357)
Fair value of plan assets, end of year	6,845	6,395
Funded status	$ 383	$ 156

The change in the pension benefit obligation during the years ended December 31, 2020 and 2019 was primarily driven by the change in the discount rate during each respective period.

The assets (liabilities) recognized on the consolidated balance sheets at December 31, 2020 and 2019 for the pension plans consisted of the following:

In millions	**2020**	**2019**
Non-current assets reflected in other assets	$ 744	$ 494
Current liabilities reflected in accrued expenses	(76)	(25)
Non-current liabilities reflected in other long-term liabilities	(285)	(313)
Net assets	$ 383	$ 156

Net Periodic Benefit Cost (Income)
The components of net periodic benefit cost (income) for the years ended December 31, 2020, 2019 and 2018 are shown below:

In millions	**2020**	**2019**	**2018**
Components of net periodic benefit cost (income):			
Interest cost	$ 168	$ 225	$ 25
Expected return on plan assets	(388)	(357)	(33)
Amortization of net actuarial loss	2	1	2
Net periodic benefit cost (income)	$ (218)	$ (131)	$ (6)

Pension Plan Assumptions
The Company uses a series of actuarial assumptions to determine its benefit obligation and net periodic benefit cost (income), the most significant of which include discount rates and expected return on plan assets assumptions.

Discount Rates - The discount rate is determined using a yield curve as of the annual measurement date. The yield curve consists of a series of individual discount rates, with each discount rate corresponding to a single point in time, based on high-quality bonds. Projected benefit payments are discounted to the measurement date using the corresponding rate from the yield curve that is consistent with the maturity profile of the expected liability cash flows.

Expected Return on Plan Assets - The expected long-term rate of return on plan assets is determined by using the plan's target allocation and return expectations based on many factors including forecasted long-term capital market real returns and the inflationary outlook on a plan by plan basis. See "Pension Plan Assets" below for additional details regarding the pension plan assets as of December 31, 2020 and 2019.

The Company also considers other assumptions including mortality, interest crediting rate, termination and retirement rates and cost of living adjustments.

The Company determined its benefit obligation based on the following weighted average assumptions as of December 31, 2020 and 2019:

	2020	**2019**
Discount rate	2.5 %	3.2 %

The Company determined its net periodic benefit cost (income) based on the following weighted average assumptions for the years ended December 31, 2020, 2019 and 2018:

	2020	**2019**	**2018**
Discount rate	2.9 %	4.0 %	4.0 %
Expected long-term rate of return on plan assets	6.3 %	6.5 %	6.6 %

Pension Plan Assets

Subsequent to the Aetna Acquisition Date, the Company's pension plan assets primarily include debt and equity securities held in separate accounts, common/collective trusts and real estate investments. The valuation methodologies used to value these debt and equity securities and common/collective trusts are similar to the methodologies described in Note 4 "Fair Value." Pension plan assets also include investments in other assets that are carried at fair value. The following is a description of the valuation methodologies used to value real estate investments and these additional investments, including the general classification pursuant to the fair value hierarchy.

Real Estate - Real estate investments are valued by independent third party appraisers. The appraisals comply with the Uniform Standards of Professional Appraisal Practice, which include, among other things, the income, cost, and sales comparison approaches to estimating property value. Therefore, these investments are classified in Level 3.

Private equity and hedge fund limited partnerships - Private equity and hedge fund limited partnerships are carried at fair value which is estimated using the NAV per unit as reported by the administrator of the underlying investment fund as a practical expedient to fair value. Therefore, these investments have been excluded from the fair value table below.

Pension plan assets with changes in fair value measured on a recurring basis at December 31, 2020 were as follows:

In millions	**Level 1**	**Level 2**	**Level 3**	**Total**
Cash and cash equivalents	$ 118	$ 81	$ —	$ 199
Debt securities:				
U.S. government securities	575	36	—	611
States, municipalities and political subdivisions	—	170	—	170
U.S. corporate securities	—	2,006	—	2,006
Foreign securities	—	167	—	167
Residential mortgage-backed securities	—	287	—	287
Commercial mortgage-backed securities	—	83	—	83
Other asset-backed securities	—	133	—	133
Redeemable preferred securities	—	5	—	5
Total debt securities	575	2,887	—	3,462
Equity securities:				
U.S. domestic	1,046	—	—	1,046
International	537	—	—	537
Domestic real estate	15	—	—	15
Total equity securities	1,598	—	—	1,598
Other investments:				
Real estate	—	—	343	343
Common/collective trusts [1]	—	266	—	266
Derivatives	—	(3)	—	(3)
Total other investments	—	263	343	606
Total pension investments [2]	$ 2,291	$ 3,231	$ 343	$ 5,865

(1) The assets in the underlying funds of common/collective trusts consist of $84 million of equity securities and $182 million of debt securities.

(2) Excludes $142 million of other receivables as well as $624 million of private equity limited partnership investments and $214 million of hedge fund limited partnership investments as these amounts are measured at NAV per share or an equivalent and are not subject to leveling within the fair value hierarchy.

Pension plan assets with changes in fair value measured on a recurring basis at December 31, 2019 were as follows:

In millions	**Level 1**	**Level 2**	**Level 3**	**Total**
Cash and cash equivalents	$ 92	$ 65	$ —	$ 157
Debt securities:				
U.S. government securities	592	31	—	623
States, municipalities and political subdivisions	—	157	—	157
U.S. corporate securities	—	1,849	1	1,850
Foreign securities	—	178	—	178
Residential mortgage-backed securities	—	385	—	385
Commercial mortgage-backed securities	—	89	—	89
Other asset-backed securities	—	150	—	150
Redeemable preferred securities	—	5	—	5
Total debt securities	592	2,844	1	3,437
Equity securities:				
U.S. domestic	931	1	—	932
International	481	—	—	481
Domestic real estate	25	—	—	25
Total equity securities	1,437	1	—	1,438
Other investments:				
Real estate	—	—	353	353
Common/collective trusts [1]	—	288	—	288
Derivatives	—	(2)	—	(2)
Total other investments	—	286	353	639
Total pension investments [2]	$ 2,121	$ 3,196	$ 354	$ 5,671

(1) The assets in the underlying funds of common/collective trusts consist of $137 million of equity securities and $151 million of debt securities.
(2) Excludes $540 million of private equity limited partnership investments and $184 million of hedge fund limited partnership investments as these amounts are measured at NAV per share or an equivalent and are not subject to leveling within the fair value hierarchy.

The changes in the balance of Level 3 pension plan assets during 2020 were as follows:

	2020		
In millions	**Real estate**	**U.S. corporate securities**	**Total**
Beginning balance	$ 353	$ 1	$ 354
Actual return on plan assets	(2)	—	(2)
Purchases, sales and settlements	(8)	—	(8)
Transfers out of Level 3	—	(1)	(1)
Ending balance	$ 343	$ —	$ 343

The changes in the balance of Level 3 pension plan assets during 2019 were as follows:

	2019		
In millions	**Real estate**	**U.S. corporate securities**	**Total**
Beginning balance	$ 425	$ 5	$ 430
Actual return on plan assets	5	—	5
Purchases, sales and settlements	(77)	(5)	(82)
Transfers into Level 3	—	1	1
Ending balance	$ 353	$ 1	$ 354

The Company's pension plan invests in a diversified mix of assets designed to generate returns that will enable the plan to meet its future benefit obligations. The risk of unexpected investment and actuarial outcomes is regularly evaluated. This evaluation is performed through forecasting and assessing ranges of investment outcomes over short- and long-term horizons and by assessing the pension plan's liability characteristics. Complementary investment styles and strategies are utilized by professional investment management firms to further improve portfolio and operational risk characteristics. Public and private equity investments are used primarily to increase overall plan returns. Real estate investments are viewed favorably for their diversification benefits and above-average dividend generation. Fixed income investments provide diversification benefits and liability hedging attributes that are desirable, especially in falling interest rate environments.

At December 31, 2020, target investment allocations for the Company's pension plan were: 20% in equity securities, 68% in fixed income and debt securities, 6% in real estate, 3% in private equity limited partnerships and 3% in hedge funds. Actual asset allocations may differ from target allocations due to tactical decisions to overweight or underweight certain assets or as a result of normal fluctuations in asset values. Asset allocations are consistent with stated investment policies and, as a general rule, periodically rebalanced back to target asset allocations. Asset allocations and investment performance are formally reviewed periodically throughout the year by the pension plan's Investment Subcommittee. Forecasting of asset and liability growth is performed at least annually.

Cash Flows

The Company generally contributes to its tax-qualified pension plan based on minimum funding requirements determined under applicable federal laws and regulations. Employer contributions related to the nonqualified supplemental pension plans generally represent payments to retirees for current benefits. The Company contributed $25 million, $25 million and $12 million to its pension plans during 2020, 2019 and 2018, respectively. No contributions are required for the tax-qualified pension plan in 2021. The Company expects to make an immaterial amount of contributions for all other pension plans in 2021. The Company estimates the following future benefit payments, which are calculated using the same actuarial assumptions used to measure the pension benefit obligation as of December 31, 2020:

In millions	
2021	$ 423
2022	376
2023	375
2024	375
2025	375
2026-2030	1,807

Multiemployer Pension Plans

The Company also contributes to a number of multiemployer pension plans under the terms of collective-bargaining agreements that cover its union-represented employees. The risks of participating in these multiemployer plans are different from single-employer pension plans in the following respects: (i) assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers, (ii) if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the

remaining participating employers, and (iii) if the Company chooses to stop participating in some of its multiemployer plans, the Company may be required to pay those plans an amount based on the underfunded status of the applicable plan, which is referred to as a withdrawal liability.

None of the multiemployer pension plans in which the Company participates are individually significant to the Company. The Company's contributions to multiemployer pension plans were $19 million, $18 million and $18 million in 2020, 2019 and 2018, respectively.

Other Postretirement Benefits

The Company provides postretirement health care and life insurance benefits to certain retirees who meet eligibility requirements. During 2018, the Company acquired additional OPEB plans in connection with the Aetna Acquisition. The Company's funding policy is generally to pay covered expenses as they are incurred. For retiree medical plan accounting, the Company reviews external data and its own historical trends for health care costs to determine the health care cost trend rates. As of December 31, 2020 and 2019, the Company's other postretirement benefits had an accumulated postretirement benefit obligation of $226 million and $246 million, respectively. Net periodic benefit costs related to these other postretirement benefits were $12 million, $7 million and $2 million in 2020, 2019 and 2018, respectively.

The Company estimates the following future benefit payments, which are calculated using the same actuarial assumptions used to measure the accumulated other postretirement benefit obligation as of December 31, 2020:

In millions	
2021	$ 13
2022	13
2023	13
2024	13
2025	13
2026-2030	61

Pursuant to various collective bargaining agreements, the Company also contributes to multiemployer health and welfare plans that cover certain union-represented employees. The plans provide postretirement health care and life insurance benefits to certain employees who meet eligibility requirements. The Company's contributions to multiemployer health and welfare plans totaled $54 million, $57 million and $58 million in 2020, 2019 and 2018, respectively.

10. Income Taxes

The income tax provision for continuing operations consisted of the following for the years ended December 31, 2020, 2019 and 2018:

In millions	**2020**	**2019**	**2018**
Current:			
Federal	$ 2,615	$ 2,450	$ 1,480
State	518	565	499
	3,133	3,015	1,979
Deferred:			
Federal	(450)	(535)	22
State	(114)	(114)	1
	(564)	(649)	23
Total	$ 2,569	$ 2,366	$ 2,002

The TCJA was enacted on December 22, 2017. Among numerous changes to existing tax laws, the TCJA permanently reduced the federal corporate income tax rate from 35% to 21% effective on January 1, 2018. The effects of changes in tax rates on deferred tax balances are required to be taken into consideration in the period in which the changes are enacted, regardless of when they are effective. As a result of the reduction of the corporate income tax rate under the TCJA, the Company estimated the revaluation of its net deferred tax liabilities and recorded a provisional income tax benefit of approximately $1.5 billion for

year ended December 31, 2017. In 2018, the Company completed its process of determining the TCJA's final impact and recorded an additional income tax benefit of $100 million.

The following table is a reconciliation of the statutory income tax rate to the Company's effective income tax rate for continuing operations for the years ended December 31, 2020, 2019 and 2018:

	2020	2019	2018
Statutory income tax rate	21.0 %	21.0 %	21.0 %
State income taxes, net of federal tax benefit	3.2	4.0	27.7
Effect of the Tax Cuts and Jobs Act	—	—	(7.1)
Health insurer fee	2.2	—	2.2
Goodwill impairments	—	—	89.5
Basis difference upon disposition of subsidiary	(1.2)	—	5.0
Other	1.1	1.3	4.1
Effective income tax rate	26.3 %	26.3 %	142.4 %

The following table is a summary of the components of the Company's deferred income tax assets and liabilities as of December 31, 2020 and 2019:

In millions	2020	2019
Deferred income tax assets:		
Lease and rents	$ 5,742	$ 5,731
Inventory	80	23
Employee benefits	238	191
Bad debts and other allowances	395	294
Retirement benefits	—	47
Net operating loss and capital loss carryforwards	568	480
Deferred income	43	36
Insurance reserves	489	430
Payroll tax deferral	173	—
Other	500	451
Valuation allowance	(454)	(374)
Total deferred income tax assets	7,774	7,309
Deferred income tax liabilities:		
Retirement benefits	(29)	—
Investments	(421)	(289)
Lease and rents	(5,368)	(5,464)
Depreciation and amortization	(8,750)	(8,850)
Total deferred income tax liabilities	(14,568)	(14,603)
Net deferred income tax liabilities	$ (6,794)	$ (7,294)

As of December 31, 2020, the Company had net operating and capital loss carryovers of $568 million, which expire between 2021 and 2040. The Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax planning strategies and the Company's recent operating results. The Company established a valuation allowance of $454 million because it does not consider it more likely than not that these deferred tax assets will be recovered.

A reconciliation of the beginning and ending balance of unrecognized tax benefits in 2020, 2019 and 2018 is as follows:

In millions	**2020**	**2019**	**2018**
Beginning balance	$ 655	$ 661	$ 344
Additions based on tax positions related to the current year	3	4	1
Additions based on tax positions related to prior years	182	115	324
Reductions for tax positions of prior years	(56)	(111)	(5)
Expiration of statutes of limitation	(2)	(7)	(2)
Settlements	(14)	(7)	(1)
Ending balance	$ 768	$ 655	$ 661

The increase in the balance of unrecognized tax benefits during 2018 was mainly due to the Aetna Acquisition.

The Company and most of its subsidiaries are subject to U.S. federal income tax as well as income tax of numerous state and local jurisdictions. The Company participated in the Compliance Assurance Process through 2019, which is a program made available by the U.S. Internal Revenue Service ("IRS") to certain qualifying large taxpayers, under which participants work collaboratively with the IRS to identify and resolve potential tax issues through open, cooperative and transparent interaction prior to the annual filing of their federal income tax returns. The IRS has completed its examinations of the Company's consolidated U.S. federal income tax returns for tax years 2013 and 2018. The IRS has substantially completed its examinations of the Company's consolidated U.S. federal income tax returns for tax years 2014 through 2017 and 2019.

The Company and its subsidiaries are also currently under income tax examinations by a number of state and local tax authorities. As of December 31, 2020, no examination has resulted in any proposed adjustments that would result in a material change to the Company's operating results, financial condition or liquidity.

Substantially all material state and local income tax matters have been concluded for fiscal years through 2014. Certain state exams are likely to be concluded and certain state statutes of limitations will lapse in 2021, but the change in the balance of the Company's uncertain tax positions is projected to be immaterial. In addition, it is reasonably possible that the Company's unrecognized tax benefits could change within the next twelve months due to the anticipated conclusion of various examinations with the IRS for various years. An estimate of the range of the possible change cannot be made at this time.

The Company records interest expense related to unrecognized tax benefits and penalties in the income tax provision. The Company accrued interest expense of approximately $34 million, $49 million and $19 million in 2020, 2019 and 2018, respectively. The Company had approximately $121 million and $173 million accrued for interest and penalties as of December 31, 2020 and 2019, respectively.

As of December 31, 2020, the total amount of unrecognized tax benefits that, if recognized, would affect the Company's effective income tax rate is approximately $651 million, after considering the federal benefit of state income taxes.

11. Stock Incentive Plans

The terms of the CVS Health 2017 Incentive Compensation Plan ("ICP") provide for grants of annual incentive and long-term performance awards to executive officers and other officers and employees of the Company or any subsidiary of the Company, as well as equity compensation to outside directors of CVS Health. Payment of such annual incentive and long-term performance awards will be in cash, stock, other awards or other property, at the discretion of the Management Planning and Development Committee (the "MP&D Committee") of CVS Health's Board of Directors (the "Board"). The ICP allows for a maximum of 58 million shares of CVS Health common stock to be reserved and available for grants. As of December 31, 2020, there were approximately 38 million shares of CVS Health common stock available for future grants under the ICP.

As of the Aetna Acquisition Date, approximately 22 million shares of Aetna common stock subject to awards outstanding under the Amended Aetna Inc. 2010 Stock Incentive Plan ("SIP") were assumed by CVS Health. In addition, in accordance with the merger agreement, shares which were available for future issuance under the SIP were converted into approximately 32 million shares of CVS Health common stock reserved and available for issuance pursuant to future awards. Subsequent to the

expiration of the SIP on May 21, 2020, the ICP is the only compensation plan under which the Company grants stock options, restricted stock and other stock-based awards to its employees.

Stock-Based Compensation Expense

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as expense over the requisite service period of the stock award (generally three to five years) using the straight-line method. The following table is a summary of stock-based compensation for the years ended December 31, 2020, 2019 and 2018:

In millions	2020	2019	2018
Stock options and stock appreciation rights ("SARs") [1] [2]	$ 71	$ 76	$ 70
Restricted stock units and performance stock units [2]	329	377	210
Total stock-based compensation	$ 400	$ 453	$ 280

(1) Includes the ESPP.

(2) Stock-based compensation for the year ended December 31, 2018 includes $14 million and $27 million associated with accelerated vesting of SARs and restricted stock replacement awards, respectively, issued to Aetna employees who were terminated subsequent to the Aetna Acquisition.

ESPP

The Company's Employee Stock Purchase Plan ("ESPP") provides for the purchase of up to 60 million shares of CVS Health common stock. Under the ESPP, eligible employees may purchase common stock at the end of each six month offering period at a purchase price equal to 90% of the lower of the fair market value on the first day or the last day of the offering period. During 2020, approximately 3 million shares of common stock were purchased under the provisions of the ESPP at an average price of $53.85 per share. As of December 31, 2020, approximately 34 million shares of common stock were available for issuance under the ESPP.

The fair value of stock-based compensation associated with the ESPP is estimated on the date of grant (the first day of the six month offering period) using the Black-Scholes option pricing model.

The following table is a summary of the assumptions used to value the ESPP awards for the years ended December 31, 2020, 2019 and 2018:

	2020	2019	2018
Dividend yield [1]	1.46 %	1.70 %	1.45 %
Expected volatility [2]	37.21 %	27.96 %	28.02 %
Risk-free interest rate [3]	0.81 %	2.27 %	1.87 %
Expected life (in years) [4]	0.5	0.5	0.5
Weighted-average grant date fair value	$ 13.85	$ 10.51	$ 12.26

(1) The dividend yield is calculated based on semi-annual dividends paid and the fair market value of CVS Health stock at the grant date.

(2) The expected volatility is estimated based on the historical volatility of CVS Health's daily stock price over the previous six month period.

(3) The risk-free interest rate is selected based on the Treasury constant maturity interest rate whose term is consistent with the expected term of ESPP purchases (i.e., six months).

(4) The expected life is based on the semi-annual purchase period.

Restricted Stock Units and Performance Stock Units

The Company's restricted stock units and performance stock units are considered nonvested share awards and require no payment from the employee. The fair value of the restricted stock units is based on the market price of CVS Health common stock on the grant date and is recognized on a straight-line basis over the vesting period. For each restricted stock unit granted, employees receive one share of common stock, net of taxes, at the end of the vesting period.

The Company’s performance stock units contain performance vesting conditions in addition to a service vesting condition. Vesting of the Company’s performance stock units is dependent upon the degree to which the Company achieves its performance goals, which are generally set for a three-year performance period and are approved at the time of grant by the MP&D Committee.

The fair value of performance stock units granted with service and performance vesting conditions is based on the market price of CVS Health common stock on the grant date and is recognized over the vesting period. Certain of the performance stock units also contain a market vesting condition based on the performance of CVS Health common stock relative to a comparator group. The fair value of these performance stock units is determined using a Monte Carlo simulation as of the grant date and is recognized over the vesting period.

On November 28, 2018, the Company completed the Aetna Acquisition. All unvested Aetna performance stock unit and restricted stock unit awards as of the Aetna Acquisition Date were converted into replacement CVS Health restricted stock awards.

As of December 31, 2020, there was $493 million of total unrecognized compensation cost related to the Company's restricted stock units and performance stock units that are expected to vest. These costs are expected to be recognized over a weighted-average period of 2.3 years. The total fair value of restricted stock units vested during 2020, 2019 and 2018 was $229 million, $265 million and $262 million, respectively.

The following table is a summary of the restricted stock unit and performance stock unit activity for the year ended December 31, 2020:

In thousands, except weighted average grant date fair value	**Units**	**Weighted Average Grant Date Fair Value**
Outstanding at beginning of year, nonvested	13,125	$ 61.57
Granted	6,849	$ 58.38
Vested	(3,793)	$ 60.40
Forfeited	(1,357)	$ 59.10
Outstanding at end of year, nonvested	14,824	$ 58.12

Stock Options and SARs

All stock option grants are awarded at fair value on the date of grant. The fair value of stock options is estimated using the Black-Scholes option pricing model, and stock-based compensation is recognized on a straight-line basis over the requisite service period. Stock options granted generally become exercisable over a four-year period from the grant date. Stock options granted through 2018 generally expire seven years after the grant date. Stock options granted subsequent to 2018 generally expire ten years after the grant date.

On November 28, 2018, the Company completed the Aetna Acquisition. All unvested Aetna SARs outstanding as of the Aetna Acquisition Date were converted into replacement CVS Health SARs. The replacement SARs granted will be settled in CVS Health common stock, net of taxes, based on the appreciation of the stock price on the exercise date over the market price on the date of grant. The fair value of SARs is estimated using the Black-Scholes option pricing model, and stock-based compensation is recognized on a straight-line basis over the requisite service period. SARs generally become exercisable over a three-year period from the grant date. SARs generally expire ten years after the grant date.

The following table is a summary of stock option and SAR activity that occurred for the years ended December 31, 2020, 2019 and 2018:

In millions	**2020**	**2019**	**2018**
Cash received from stock options exercised (including ESPP)	$ 264	$ 210	$ 242
Payments for taxes for net share settlement of equity awards	88	112	97
Intrinsic value of stock options and SARs exercised	24	30	79
Fair value of stock options and SARs vested	252	467	324

The fair value of each stock option and SAR is estimated using the Black-Scholes option pricing model based on the following assumptions at the time of grant:

	2020	2019	2018
Dividend yield [1]	3.42 %	3.68 %	2.76 %
Expected volatility [2]	25.22 %	21.76 %	21.27 %
Risk-free interest rate [3]	0.61 %	0.56 %	2.77 %
Expected life (in years) [4]	6.3	6.3	4.8
Weighted-average grant date fair value	$ 8.78	$ 6.27	$ 24.55

(1) The dividend yield is based on annual dividends paid and the fair market value of CVS Health stock at the grant date.

(2) The expected volatility is estimated based on the historical volatility of CVS Health's daily stock price over a period equal to the expected life of each option or SAR grant after adjustments for infrequent events such as stock splits.

(3) The risk-free interest rate is selected based on yields from U.S. Treasury zero-coupon issues with a remaining term equal to the expected term of the options or SARs being valued.

(4) The expected life represents the number of years the options or SARs are expected to be outstanding from grant date based on historical option or SAR holder exercise experience.

The increase in the weighted-average grant date fair value in 2018 was due to the issuance of the replacement SARs in connection with the Aetna Acquisition in the year ended December 31, 2018.

As of December 31, 2020, unrecognized compensation expense related to unvested stock options and SARs totaled $45 million, which the Company expects to be recognized over a weighted-average period of 1.8 years. After considering anticipated forfeitures, the Company expects approximately 10 million of the unvested stock options and SARs to vest over the requisite service period.

The following table is a summary of the Company's stock option and SAR activity for the year ended December 31, 2020:

In thousands, except weighted average exercise price and remaining contractual term	Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term	Aggregate Intrinsic Value
Outstanding at beginning of year	23,902	$ 69.98		
Granted	4,759	$ 58.50		
Exercised	(2,601)	$ 52.95		
Forfeited	(1,164)	$ 57.61		
Expired	(941)	$ 83.34		
Outstanding at end of year	23,955	$ 69.62	4.86	$ 185,487
Exercisable at end of year	13,545	$ 78.05	2.79	78,289
Vested at end of year and expected to vest in the future	23,448	$ 69.87	4.78	180,102

12. Shareholders' Equity

Share Repurchases

The following share repurchase program has been authorized by the Board:

In billions Authorization Date	Authorized	Remaining as of December 31, 2020
November 2, 2016 ("2016 Repurchase Program")	$ 15.0	$ 13.9

The 2016 Repurchase Program permits the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase transactions, and/or other derivative transactions. The 2016 Repurchase Program can be modified or terminated by the Board at any time.

During the years ended December 31, 2020, 2019 and 2018, the Company did not repurchase any shares of common stock pursuant to the 2016 Repurchase Program.

Dividends

The quarterly cash dividend declared by the Board was $0.50 per share in 2020 and 2019. CVS Health has paid cash dividends every quarter since becoming a public company. Future dividend payments will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

Regulatory Requirements

On November 28, 2018, the Company completed the Aetna Acquisition. Aetna's insurance business operations are conducted through subsidiaries that principally consist of HMOs and insurance companies. The Company's HMO and insurance subsidiaries report their financial statements in accordance with accounting practices prescribed by state regulatory authorities which may differ from GAAP. The combined statutory net income for the years ended and estimated combined statutory and capital surplus at December 31, 2020, 2019 and 2018 for the Company's insurance and HMO subsidiaries were as follows:

In millions	**2020**	**2019**	**2018**
Statutory net income [1]	$ 3,667	$ 2,842	NM
Estimated statutory capital and surplus	13,238	10,975	10,084

(1) Statutory net income of the Company's insurance and HMO subsidiaries for the year ended December 31, 2018 (which includes Aetna and its subsidiaries from November 28, 2018 to December 31, 2018) is not material ("NM").

The Company's insurance and HMO subsidiaries paid $3.1 billion of gross dividends to the Company for the year ended December 31, 2020.

In addition to general state law restrictions on payments of dividends and other distributions to stockholders applicable to all corporations, HMOs and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity and restrict the amount of dividends and other distributions that may be paid to their equity holders. In addition, in connection with the Aetna Acquisition, the Company made certain undertakings that require prior regulatory approval of dividends by certain of its HMOs and insurance companies. At December 31, 2020, these amounts were as follows:

In millions	
Estimated minimum statutory surplus required by regulators	$ 5,395
Investments on deposit with regulatory bodies	712
Estimated maximum dividend distributions permitted in 2021 without prior regulatory approval	2,900

Noncontrolling Interests

At December 31, 2020 and 2019, noncontrolling interests were $312 million and $306 million, respectively, primarily related to third party interests in the Company's operating entities. The noncontrolling entities' share is included in total shareholders' equity on the consolidated balance sheets.

13. Other Comprehensive Income

Shareholders' equity included the following activity in accumulated other comprehensive income in 2020, 2019 and 2018:

	At December 31,		
In millions	**2020**	**2019**	**2018**
Net unrealized investment gains:			
Beginning of year balance	$ 774	$ 97	$ —
Other comprehensive income before reclassifications *($497, $927 and $132 pretax)*	415	763	97
Amounts reclassified from accumulated other comprehensive income *($31, $ (105) and $1 pretax)* [1]	25	(86)	—
Other comprehensive income	440	677	97
End of year balance	1,214	774	97
Foreign currency translation adjustments:			
Beginning of year balance	4	(158)	(129)
Other comprehensive income (loss) before reclassifications	3	8	(29)
Amounts reclassified from accumulated other comprehensive income (loss) [2]	—	154	—
Other comprehensive income (loss)	3	162	(29)
End of year balance	7	4	(158)
Net cash flow hedges:			
Beginning of year balance	279	312	(15)
Adoption of new accounting standard [3]	—	—	(3)
Other comprehensive income (loss) before reclassifications *($(7), $(25) and $465 pretax)*	(5)	(18)	344
Amounts reclassified from accumulated other comprehensive income (loss) *($ (35), $(20) and $(19) pretax)* [4]	(26)	(15)	(14)
Other comprehensive income (loss)	(31)	(33)	330
End of year balance	248	279	312
Pension and other postretirement benefits:			
Beginning of year balance	(38)	(149)	(21)
Adoption of new accounting standard [3]	—	—	(4)
Other comprehensive income (loss) before reclassifications *($(30), $162 and $ (178) pretax)*	(22)	120	(132)
Amounts reclassified from accumulated other comprehensive loss *($7, $(12) and $11 pretax)* [5]	5	(9)	8
Other comprehensive income (loss)	(17)	111	(124)
End of year balance	(55)	(38)	(149)
Total beginning of year accumulated other comprehensive income (loss)	1,019	102	(165)
Adoption of new accounting standard [3]	—	—	(7)
Total other comprehensive income	395	917	274
Total end of year accumulated other comprehensive income	$ 1,414	$ 1,019	$ 102

(1) Amounts reclassified from accumulated other comprehensive income for specifically identified debt securities are included in net investment income in the consolidated statements of operations.

(2) Amounts reclassified from accumulated other comprehensive loss represent the elimination of the cumulative translation adjustment associated with the sale of Onofre, which was sold on July 1, 2019. The loss on the divestiture of Onofre is reflected in operating expenses in the consolidated statements of operations.

(3) Reflects the adoption of ASU 2018-02, *Income Statement Reporting Comprehensive Income (Topic 220); Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income* during the year ended December 31, 2018.

(4) Amounts reclassified from accumulated other comprehensive income (loss) for specifically identified cash flow hedges are included within interest expense in the consolidated statements of operations. The Company expects to reclassify approximately $13 million, net of tax, in net gains associated with its cash flow hedges into net income within the next 12 months.

(5) Amounts reclassified from accumulated other comprehensive loss for specifically identified pension and other postretirement benefits are included in other income in the consolidated statements of operations.

14. Earnings (Loss) Per Share

Earnings (loss) per share is computed using the two-class method. For periods in which the Company reports net income, diluted earnings per share is determined by using the weighted average number of common and dilutive common equivalent shares outstanding during the period, unless the effect is antidilutive. SARs and options to purchase 15 million and 17 million shares of common stock were outstanding, but were excluded from the calculation of diluted earnings per share for the years ended December 31, 2020 and 2019, respectively, because their exercise prices were greater than the average market price of the common shares and, therefore, the effect would be antidilutive. For the same reason, options to purchase 13 million shares of common stock were outstanding, but were excluded from the calculation of diluted earnings per share, for the year ended December 31, 2018. In addition, due to the loss from continuing operations attributable to CVS Health in the year ended December 31, 2018, 3 million potentially dilutive common equivalent shares were excluded from the calculation of diluted earnings per share, as the impact of these shares was antidilutive for that period.

The following is a reconciliation of basic and diluted earnings (loss) per share from continuing operations for the years ended December 31, 2020, 2019 and 2018:

In millions, except per share amounts	**2020**	**2019**	**2018**
Numerator for earnings (loss) per share calculation:			
Income (loss) from continuing operations	$ 7,201	$ 6,631	$ (596)
Income allocated to participating securities	—	(5)	(3)
Net (income) loss attributable to noncontrolling interests	(13)	3	2
Income (loss) from continuing operations attributable to CVS Health	$ 7,188	$ 6,629	$ (597)
Denominator for earnings (loss) per share calculation:			
Weighted average shares, basic	1,309	1,301	1,044
Effect of dilutive securities	5	4	—
Weighted average shares, diluted	1,314	1,305	1,044
Earnings (loss) per share from continuing operations:			
Basic	$ 5.49	$ 5.10	$ (0.57)
Diluted	$ 5.47	$ 5.08	$ (0.57)

15. Reinsurance

The Company utilizes reinsurance agreements primarily to: (a) reduce required capital and (b) facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit the Company to recover a portion of its losses from reinsurers, although they do not discharge the Company's primary liability as the direct insurer of the risks reinsured.

On November 30, 2018, the Company completed the sale of Aetna's standalone Medicare Part D prescription drug plans to a subsidiary of WellCare Health Plans, Inc. ("WellCare"), effective December 31, 2018. In connection with that sale, subsidiaries of WellCare and Aetna entered into reinsurance agreements under which WellCare ceded to Aetna 100% of the insurance risk related to the divested standalone Medicare Part D prescription drug plans for the 2019 PDP plan year.

In February 2021, the Company entered into two four-year reinsurance agreements with an unrelated reinsurer that allow it to reduce required capital and provide collateralized excess of loss reinsurance coverage on a portion of the Health Care Benefits segment's group Commercial Insured business.

Reinsurance recoverables (recorded as other current assets or other assets on the consolidated balance sheets) at December 31, 2020 and 2019 were as follows:

In millions	**2020**	**2019**
Reinsurer		
Hartford Life and Accident Insurance Company	$ 2,364	$ 3,085
Lincoln Life & Annuity Company of New York	406	413
WellCare Health Plans	13	355
VOYA Retirement Insurance and Annuity Company	170	175
All Other	102	103
Total	$ 3,055	$ 4,131

Direct, assumed and ceded premiums earned for the years ended December 31, 2020, 2019 and 2018 were as follows:

In millions	**2020**	**2019**	**2018**
Direct	$ 69,711	$ 62,968	$ 8,365
Assumed	478	2,108	38
Ceded	(825)	(1,954)	(219)
Net premiums	$ 69,364	$ 63,122	$ 8,184

The impact of reinsurance on benefit costs for the years ended December 31, 2020, 2019 and 2018 were as follows:

In millions	**2020**	**2019**	**2018**
Direct	$ 56,077	$ 52,592	$ 6,773
Assumed	329	1,562	32
Ceded	(727)	(1,625)	(211)
Net benefit costs	$ 55,679	$ 52,529	$ 6,594

There is not a material difference between premiums on a written basis versus an earned basis.

The Company also has various agreements with unrelated reinsurers that do not qualify for reinsurance accounting under GAAP, and consequently are accounted for using deposit accounting. The Company entered into these contracts to reduce the risk of catastrophic loss which in turn reduces the Company's capital and surplus requirements. Total deposit assets and liabilities related to reinsurance agreements that do not qualify for reinsurance accounting under GAAP were not material as of December 31, 2020 or 2019.

16. Commitments and Contingencies

COVID-19

The COVID-19 pandemic continues to evolve. We believe COVID-19's impact on our businesses, operating results, cash flows and/or financial condition primarily will be driven by the geographies impacted and the severity and duration of the pandemic; the pandemic's impact on the U.S. and global economies and consumer behavior and health care utilization patterns; and the timing, scope and impact of stimulus legislation as well as other federal, state and local governmental responses to the pandemic. Those primary drivers are beyond our knowledge and control. As a result, the impact COVID-19 will have on our businesses, operating results, cash flows and/or financial condition is uncertain, but the impact could be adverse and material. COVID-19 also may result in legal and regulatory proceedings, investigations and claims against us.

Guarantees

The Company has the following significant guarantee arrangements at December 31, 2020:

- ASC Claim Funding Accounts - The Company has arrangements with certain banks for the processing of claim payments for its ASC customers. The banks maintain accounts to fund claims of the Company’s ASC customers. The customer is

responsible for funding the amount paid by the bank each day. In these arrangements, the Company guarantees that the banks will not sustain losses if the responsible ASC customer does not properly fund its account. The aggregate maximum exposure under these arrangements is generally limited to $250 million. The Company can limit its exposure to these guarantees by suspending the payment of claims for ASC customers that have not adequately funded the amount paid by the bank.

- Separate Accounts Assets - Certain Separate Accounts assets associated with the large case pensions business in the Corporate/Other segment represent funds maintained as a contractual requirement to fund specific pension annuities that the Company has guaranteed. Minimum contractual obligations underlying the guaranteed benefits in these Separate Accounts were approximately $1.4 billion at both December 31, 2020 and 2019. See Note 1 "Significant Accounting Policies" for additional information on Separate Accounts. Contract holders assume all investment and mortality risk and are required to maintain Separate Accounts balances at or above a specified level. The level of required funds is a function of the risk underlying the Separate Account's investment strategy. If contract holders do not maintain the required level of Separate Accounts assets to meet the annuity guarantees, the Company would establish an additional liability. Contract holders' balances in the Separate Accounts at December 31, 2020 exceeded the value of the guaranteed benefit obligation. As a result, the Company was not required to maintain any additional liability for its related guarantees at December 31, 2020.

Lease Guarantees

Between 1995 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores and Linens 'n Things, each of which subsequently filed for bankruptcy, and Marshalls. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the former subsidiary's lease obligations for the initial lease term and any extension thereof pursuant to a renewal option provided for in the lease prior to the time of the disposition. When the subsidiaries were disposed of and accounted for as discontinued operations, the Company's guarantees remained in place, although each initial purchaser agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries fail to make the required payments under a store lease, the Company could be required to satisfy those obligations, and any significant adverse impact of COVID-19 on such purchasers and/or former subsidiaries increases the risk that the Company will be required to satisfy those obligations. As of December 31, 2020, the Company guaranteed 76 such store leases (excluding the lease guarantees related to Linens 'n Things, which have been recorded as a liability on the consolidated balance sheets), with the maximum remaining lease term extending through 2030.

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers and life insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. The Company has recorded a liability for its estimated share of future assessments by applicable life and health insurance guaranty associations. It is reasonably possible that in the future the Company may record a liability and expense relating to other insolvencies which could have a material adverse effect on the Company's operating results, financial condition and cash flows, and the risk is heightened by any significant adverse impact of the COVID-19 pandemic on the solvency of other insurers, including long-term care and life insurers. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that limit future offsets.

HMOs in certain states in which the Company does business are subject to assessments, including market stabilization and other risk-sharing pools, for which the Company is assessed charges based on incurred claims,

demographic membership mix and other factors. The Company establishes liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments the Company pays are dependent upon the Company's experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of

the assessment is dependent upon the experience of all pool participants, the Company believes it has adequate reserves to cover such assessments.

The Company's total guaranty fund assessments liability was $78 million and $84 million at December 31, 2020 and 2019, respectively, and was recorded in accrued expenses on the consolidated balance sheets.

Litigation and Regulatory Proceedings

The Company has been involved or is currently involved in numerous legal proceedings, including litigation, arbitration, government investigations, audits, reviews and claims. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the U.S. Drug Enforcement Administration (the "DEA") and other governmental authorities.

Legal proceedings, in general, and securities, class action and multi-district litigation, in particular, and governmental special investigations, audits and reviews can be expensive and disruptive. Some of the litigation matters may purport or be determined to be class actions and/or involve parties seeking large and/or indeterminate amounts, including punitive or exemplary damages, and may remain unresolved for several years. The Company also may be named from time to time in *qui tam* actions initiated by private third parties that could also be separately pursued by a governmental body. The results of legal proceedings, including government investigations, are often uncertain and difficult to predict, and the costs incurred in these matters can be substantial, regardless of the outcome.

The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and reasonably estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial condition.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. The Company believes that its defenses and assertions in pending legal proceedings have merit and does not believe that any of these pending matters, after consideration of applicable reserves and rights to indemnification, will have a material adverse effect on the Company's financial position. Substantial unanticipated verdicts, fines and rulings, however, do sometimes occur, which could result in judgments against the Company, entry into settlements or a revision to its expectations regarding the outcome of certain matters, and such developments could have a material adverse effect on its results of operations. In addition, as a result of governmental investigations or proceedings, the Company may be subject to damages, civil or criminal fines or penalties, or other sanctions including possible suspension or loss of licensure and/or exclusion from participating in government programs. The outcome of such governmental investigations of proceedings could be material to the Company.

Usual and Customary Pricing Litigation

The Company and certain current and former directors and officers are named as a defendant in a number of lawsuits that allege that the Company's retail pharmacies overcharged for prescription drugs by not submitting the correct usual and customary price during the claims adjudication process. These actions are brought by a number of different types of plaintiffs, including plan members, private payors, government payors, and shareholders based on different legal theories. Some of these cases are brought as putative class actions, and in some instances, classes have been certified. The Company is defending itself against these claims.

PBM Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning its PBM practices.

The Company is facing multiple lawsuits, including several putative class actions, regarding drug pricing and its rebate arrangements with drug manufacturers. These complaints, brought under a variety of legal theories, generally

allege that rebate agreements between the drug manufacturers and PBMs caused inflated prices for certain drug products. The Company is defending itself against these claims. The Company has also received subpoenas, civil investigative demands ("CIDs") and

other requests for documents and information from, and is being investigated by, Attorneys General of several states and the District of Columbia regarding its PBM practices, including pricing and rebates. The Company has been providing documents and information in response to these subpoenas, CIDs and requests for information.

United States ex rel. Behnke v. CVS Caremark Corporation, et al. (U.S. District Court for the Eastern District of Pennsylvania). In April 2018, the Court unsealed a complaint filed in February 2014. The government has declined to intervene in this case. The relator alleges that the Company submitted, or caused to be submitted, to Part D of the Medicare program Prescription Drug Event data and/or Direct and Indirect Remuneration reports that misrepresented true prices paid by the Company's PBM to pharmacies for drugs dispensed to Part D beneficiaries with prescription benefits administered by the Company's PBM. The Company is defending itself against these claims.

Controlled Substances Litigation, Audits and Subpoenas

In December 2017, the U.S. Judicial Panel on Multidistrict Litigation consolidated numerous cases filed against various defendants by plaintiffs such as counties, cities, hospitals, Indian tribes and third-party payors, alleging claims generally concerning the impacts of widespread prescription opioid abuse. The consolidated multidistrict litigation captioned *In re National Prescription Opiate Litigation* (MDL No. 2804) is pending in the U.S. District Court for the Northern District of Ohio. This multidistrict litigation presumptively includes hundreds of relevant federal court cases that name the Company as a defendant. A significant number of similar cases that name the Company as a defendant in some capacity are pending in state courts. In addition, the Company has been named as a defendant in similar cases brought by certain state Attorneys General. The Company is defending itself against all such claims. Additionally, the Company has received subpoenas, CIDs and/or other requests for information regarding opioids from state Attorneys General and insurance and other regulators of several U.S. jurisdictions. The Company has been cooperating with the government with respect to these subpoenas, CIDs and other requests for information.

In January 2020, the U.S. Department of Justice (the "DOJ") served the Company with a DEA administrative subpoena. The subpoena seeks documents relating to practices with respect to prescription opioids and other controlled substances at CVS Pharmacy locations in connection with an investigation concerning potential violations of the federal Controlled Substances Act and the federal False Claims Act. The Company has been cooperating with the government with respect to this subpoena.

Prescription Processing Litigation and Investigations

U.S. ex rel. *Bassan* et al. *v. Omnicare, Inc. and CVS Health Corp.* and *U.S.* ex rel. *Mohajer* et al. *v. Omnicare, Inc. and CVS Health Corp.* (U.S. District Court for the Southern District of New York). In December 2019, the U.S. Attorney's Office for the Southern District of New York (the "SDNY") filed complaints-in-intervention in these two previously sealed *qui tam* cases. With respect to the *Bassan* complaint, all states and Washington, D.C. have declined to intervene at this time. The government's investigation related to these complaints included the previously disclosed CID that the Company received in October 2015 from the SDNY concerning the Company's Omnicare pharmacies' cycle fill process for assisted living facilities. The complaints allege that for certain non-skilled nursing facilities, Omnicare improperly filled prescriptions beyond one year where a valid prescription did not exist and that these dispensing events violated the federal False Claims Act. The *Mohajer* relators have amended their complaint to include claims based on similar theories related to certain skilled nursing facilities. The Company is defending itself against these claims.

In July 2017, the Company also received a subpoena from the California Department of Insurance requesting documents concerning the Company's Omnicare pharmacies' cycle fill process for assisted living facilities. The Company has been cooperating with the California Department of Insurance and providing documents and information in response to this subpoena..

In December 2016, the Company received a CID from the U.S. Attorney's Office for the Northern District of New York requesting documents and information in connection with a federal False Claims Act investigation concerning whether the Company's retail pharmacies improperly submitted certain insulin claims to Part D of the Medicare program rather than Part B of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to this CID.

Provider Proceedings

The Company is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by providers with whom the Company has a contract and with

whom the Company does not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that the Company paid too little to its health plan members and/or providers for out-of-network services and/or otherwise allege that the Company failed to timely or appropriately pay or administer out-of-network claims and benefits (including the Company's post-payment audit and collection practices and reductions in payments to providers due to sequestration). Other major health insurers are the subject of similar litigation or have settled similar litigation.

The Company also has received subpoenas and/or requests for documents and other information from, and been investigated by, state Attorneys General and other state and/or federal regulators, legislators and agencies relating to, and the Company is involved in other litigation regarding, its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against the Company with respect to its out-of-network benefit payment and/or administration practices.

CMS Actions

CMS regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to the Company's and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by providers. The Company collects claim and encounter data from providers and generally relies on providers to appropriately code their submissions to the Company and document their medical records, including the diagnosis data submitted to the Company with claims. CMS pays increased premiums to Medicare Advantage plans and Medicare PDP plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to the Company. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by providers and the resulting risk adjusted premium payments to the plans. CMS may require the Company to refund premium payments if the Company's risk adjusted premiums are not properly supported by medical record data. The Office of the Inspector General of the U.S. Department of Health and Human Services ("HHS-OIG") also is auditing the Company's risk adjustment-related data and that of other companies. The Company expects CMS and the OIG to continue these types of audits.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will extrapolate the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. For contract years prior to 2011, CMS did not extrapolate sample error rates to the entire contract. As a result, the revised methodology may increase the Company's exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various contract years for RADV audit, and the number of RADV audits continues to increase. The Company is currently unable to predict which of its Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to the Company, the effect of any such refunds or adjustments on the actuarial soundness of the Company's Medicare Advantage bids, or whether any RADV audit findings would require the Company to change its method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in the Company's bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange-related or other audits by CMS, HHS-OIG or otherwise, including audits of the Company's MLR rebates, methodology and/or reports, could be material and could adversely affect the Company's operating results, cash flows and/or financial condition.

Medicare and Medicaid CIDs

The Company has received CIDs from the Civil Division of the DOJ in connection with a current investigation of the Company's patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

In May 2017, the Company received a CID from the SDNY requesting documents and information concerning possible false claims submitted to Medicare in connection with reimbursements for prescription drugs under the Medicare Part D program. The Company has been cooperating with the government and providing documents and information in response to this CID.

In April 2020, the Company received a CID from the Office of the Washington Attorney General, Medicaid Fraud Control Division, on behalf of the State of Washington and all other states, as well as the District of Columbia, Puerto Rico and the U.S. Virgin Islands. The investigation involves, among other things, possible retention of overpayments and possible submission of false claims for Medicaid reimbursement relating to drugs prescribed by providers who were excluded by the applicable federal and/or state Medicaid programs. The Company is cooperating with the government with respect to this investigation.

Stockholder Matters

Beginning in February 2019, multiple class action complaints, as well as a derivative complaint were filed by putative plaintiffs against the Company and certain current and former officers and directors. The plaintiffs in these cases assert a variety of causes of action under federal securities laws that are premised on allegations that the defendants made certain omissions and misrepresentations relating to the performance of the Company's LTC business unit. Since filing, several of the cases have been consolidated, and the first-filed federal case, *City of Miami Fire Fighters' and Police Officers' Retirement Trust,* et al. (formerly known as *Anarkat*), was recently dismissed with prejudice. The Company and its current and former officers and directors are defending themselves against these claims.

In August and September 2020, two ERISA class actions were filed in the U.S. District Court for the District of Connecticut against CVS Health, Aetna, and several current and former executives, directors and/or members of Aetna's Compensation and Talent Management Committee: *Radcliffe v. Aetna Inc.,* et al. and *Flaim v. Aetna Inc.,* et al. The plaintiffs in these cases assert a variety of causes of action premised on allegations that the defendants breached fiduciary duties and engaged in prohibited transactions relating to participants in the Aetna 401(k) Plan's investment in company stock between December 3, 2017 and February 20, 2019, claiming losses related to the performance of the Company's LTC business unit. The district court consolidated the actions and the Company has moved to dismiss the amended and consolidated class action complaint. The Company also received a related document request pursuant to ERISA § 104(b), to which the Company has responded.

Other Legal and Regulatory Proceedings.

The Company is also a party to other legal proceedings and is subject to government investigations, inquiries and audits and has received and is cooperating with the government in response to CIDs, subpoenas or similar process from various governmental agencies requesting information. These other legal proceedings and government actions include claims of or relating to bad faith, medical or professional malpractice, claims processing, dispensing of medications, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits, provider network structure (including the use of performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure or use of personal information, anticompetitive practices, general contractual matters, product liability, intellectual property litigation and employment litigation. Some of these other legal proceedings are or are purported to be class actions or derivative claims. The Company is defending itself against the claims brought in these matters.

Awards to the Company and others of certain government contracts, particularly Medicaid contracts and other contracts with government customers in the Company's Health Care Benefits segment, frequently are subject to protests by unsuccessful bidders. These protests may result in awards to the Company being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect the Company's operating results. The Company will continue to defend contract awards it receives.

There also continues to be a heightened level of review and/or audit by regulatory authorities and legislators of, and increased litigation regarding, the Company's and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including manufacturers' rebates, pricing, the use of narrow

networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health care company, the Company regularly is the subject of government actions of the types described above. These government actions may prevent or delay the Company from implementing planned premium rate increases and may result, and have resulted, in restrictions on the Company's businesses, changes to or clarifications of the Company's business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the

federal government, withholding of premium payments to the Company by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

The Company can give no assurance that its businesses, financial condition, operating results and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state government investigations of one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

17. Segment Reporting

The Company has three operating segments, Pharmacy Services, Retail/LTC and Health Care Benefits, as well as a Corporate/Other segment. The Company's segments maintain separate financial information, and the CODM evaluates the segments' operating results on a regular basis in deciding how to allocate resources among the segments and in assessing segment performance. The CODM evaluates the performance of the Company's segments based on adjusted operating income which is defined as operating income (GAAP measure) excluding the impact of amortization of intangible assets and other items, if any, that neither relate to the ordinary course of the Company's business nor reflect the Company's underlying business performance. See the reconciliation of consolidated operating income (GAAP measure) to adjusted operating income below for further context regarding the items excluded from operating income in determining adjusted operating income. The Company uses adjusted operating income as its principal measure of segment performance as it enhances the Company's ability to compare past financial performance with current performance and analyze underlying business performance and trends. Non-GAAP financial measures the Company discloses, such as consolidated adjusted operating income, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

In 2020 and 2019, revenues from the federal government accounted for 14% and 13%, respectively, of the Company's consolidated total revenues, primarily related to contracts with CMS for coverage of Medicare-eligible individuals within the Health Care Benefits segment. Revenues from the federal government were less than 10% of the Company's consolidated revenues in 2018. In 2018, approximately 9.8% of the Company's consolidated revenues were from Aetna, which was a Pharmacy Services segment client. On the Aetna Acquisition Date, Aetna became a wholly-owned subsidiary of CVS Health. Subsequent to the Aetna Acquisition Date, transactions with Aetna continue to be reported within the Pharmacy Services segment, but are eliminated in the Company's consolidated financial statements.

The following is a reconciliation of financial measures of the Company's segments to the consolidated totals:

In millions	Pharmacy Services [1]	Retail/ LTC	Health Care Benefits	Corporate/ Other	Intersegment Eliminations	Consolidated Totals
2020:						
Revenues from external customers	$ 132,663	$ 60,208	$ 74,926	$ 111	$ —	$ 267,908
Intersegment revenues	9,275	30,990	58	—	(40,323)	—
Net investment income	—	—	483	315	—	798
Total revenues	141,938	91,198	75,467	426	(40,323)	268,706
Adjusted operating income (loss)	5,688	6,146	6,188	(1,306)	(708)	16,008
Depreciation and amortization	612	1,801	1,832	196	—	4,441
2019:						
Revenues from external customers	130,428	56,258	68,979	100	—	255,765
Intersegment revenues	11,063	30,350	26	—	(41,439)	—
Net investment income	—	—	599	412	—	1,011
Total revenues	141,491	86,608	69,604	512	(41,439)	256,776
Adjusted operating income (loss)	5,129	6,705	5,202	(1,000)	(697)	15,339
Depreciation and amortization	766	1,723	1,721	161	—	4,371
2018:						
Revenues from external customers	130,012	54,999	8,904	4	—	193,919
Intersegment revenues	4,724	28,990	—	—	(33,714)	—
Net investment income	—	—	58	602	—	660
Total revenues	134,736	83,989	8,962	606	(33,714)	194,579
Adjusted operating income (loss)	4,955	7,403	528	(856)	(769)	11,261
Depreciation and amortization	710	1,698	172	138	—	2,718

(1) Total revenues of the Pharmacy Services segment include approximately $10.9 billion, $11.5 billion and $11.4 billion of retail co-payments for 2020, 2019 and 2018, respectively. See Note 1 "Significant Accounting Policies" for additional information about retail co-payments.

The following is a reconciliation of consolidated operating income to adjusted operating income for the years ended December 31, 2020, 2019 and 2018:

In millions	**2020**	**2019**	**2018**
Operating income (GAAP measure)	$ 13,911	$ 11,987	$ 4,021
Amortization of intangible assets [1]	2,341	2,436	1,006
Acquisition-related transaction and integration costs [2]	332	480	492
(Gain) loss on divestiture of subsidiary [3]	(269)	205	86
Receipt of fully reserved ACA risk corridor receivable [4]	(307)	—	—
Store rationalization charges [5]	—	231	—
Goodwill impairments [6]	—	—	6,149
Impairment of long-lived assets [7]	—	—	43
Interest income on financing for the Aetna Acquisition [8]	—	—	(536)
Adjusted operating income	$ 16,008	$ 15,339	$ 11,261

(1) The Company's acquisition activities have resulted in the recognition of intangible assets as required under the acquisition method of accounting which consist primarily of trademarks, customer contracts/relationships, covenants not to compete, technology, provider networks and value of business acquired. Definite-lived intangible assets are amortized over their estimated useful lives and are tested for impairment when events indicate that the carrying value may not be recoverable. The amortization of intangible assets is reflected in the Company's GAAP consolidated statements of operations in operating expenses within each segment. Although intangible assets contribute to the Company's revenue generation, the amortization of intangible assets does not directly relate to the underwriting of the Company's insurance products, the services performed for the Company's customers or the sale of the Company's products or services. Additionally, intangible asset amortization expense typically fluctuates based on the size and timing of the Company's acquisition activity. Accordingly, the Company believes excluding the amortization of intangible assets enhances the Company's and investors' ability to compare the Company's past financial performance with its current performance and to analyze underlying business performance and trends. Intangible asset amortization excluded from the related non-GAAP financial measure represents the entire amount recorded within the Company's GAAP financial statements, and the revenue generated by the associated intangible assets has not been excluded from the related non-GAAP financial measure. Intangible asset amortization is excluded from the related non-GAAP financial measure because the amortization, unlike the related revenue, is not affected by operations of any particular period unless an intangible asset becomes impaired or the estimated useful life of an intangible asset is revised.

(2) In 2020, 2019 and 2018, acquisition-related transaction and integration costs relate to the Aetna Acquisition. In 2018, acquisition-related integration costs also relate to the acquisition of Omnicare. The acquisition-related transaction and integration costs are reflected in the Company's consolidated statements of operations in operating expenses within the Corporate/Other segment and the Retail/LTC segment.

(3) In 2020, the gain on divestiture of subsidiary represents the pre-tax gain on the sale of the Workers' Compensation business, which the Company sold on July 31, 2020 for approximately $850 million. The gain on divestiture is reflected as a reduction in operating expenses in the Company's consolidated statement of operations within the Health Care Benefits segment. In 2019, the loss on divestiture of subsidiary represents the pre-tax loss on the sale of Onofre, which occurred on July 1, 2019. The loss on divestiture primarily relates to the elimination of the cumulative translation adjustment from accumulated other comprehensive income. In 2018, the loss on divestiture of subsidiary represents the pre-tax loss on the sale of the Company's RxCrossroads subsidiary for $725 million on January 2, 2018. The losses on divestiture of subsidiary are reflected in the Company's consolidated statements of operations in operating expenses within the Retail/LTC segment.

(4) In 2020, the Company received $313 million owed to it under the ACA's risk corridor program that was previously fully reserved for as payment was uncertain. After considering offsetting items such as the ACA's minimum MLR rebate requirements and premium taxes, the Company recognized pre-tax income of $307 million in the Company's consolidated statement of operations within the Health Care Benefits segment.

(5) In 2019, the store rationalization charges relate to the planned closure of 46 underperforming retail pharmacy stores in the second quarter of 2019 and the planned closure of 22 underperforming retail pharmacy stores in the first quarter of 2020. The store rationalization charges primarily relate to operating lease right-of-use asset impairment charges and are reflected in the Company's consolidated statement of operations in operating expenses within the Retail/LTC segment.

(6) In 2018, the goodwill impairments relate to the LTC reporting unit within the Retail/LTC segment.

(7) In 2018, impairment of long-lived assets primarily relates to the impairment of property and equipment within the Retail/LTC segment and is reflected in operating expenses in the Company's consolidated statement of operations.

(8) In 2018, the Company recorded interest income of $536 million on the proceeds of the $40 billion of unsecured senior notes it issued in March 2018 to partially fund the Aetna Acquisition. All amounts are for the periods prior to the close of the Aetna Acquisition, which occurred on November 28, 2018, and were recorded within the Corporate/Other segment.

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Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of CVS Health Corporation

Opinion on Internal Control over Financial Reporting

We have audited CVS Health Corporation's internal control over financial reporting as of December 31, 2020, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, CVS Health Corporation (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2020, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the 2020 consolidated financial statements of the Company and our report dated February 16, 2021, expressed an unqualified opinion thereon.

Basis for Opinion

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

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

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

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ Ernst & Young LLP

Boston, Massachusetts
February 16, 2021

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of CVS Health Corporation

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of CVS Health Corporation (the Company) as of December 31, 2020 and 2019, the related consolidated statements of operations, comprehensive income (loss), shareholders' equity and cash flows for each of the three years in the period ended December 31, 2020, and the related notes (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2020 and 2019, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2020, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2020, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated February 16, 2021, expressed an unqualified opinion thereon.

Basis for Opinion

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

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

Critical Audit Matters

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

Impairment of goodwill of the Commercial Business reporting unit

Description of the Matter

At December 31, 2020, the Company's goodwill related to the Commercial Business reporting unit was $26.5 billion. As discussed in Note 1 to the consolidated financial statements, goodwill is not amortized, but rather is subject to an annual impairment review, or more frequent reviews, if events and circumstances indicate an impairment exists.

Auditing management's annual goodwill impairment test related to the Commercial Business reporting unit was complex and highly judgmental due to the significant estimation required to determine the fair value of the reporting unit. In particular, the fair value estimate was sensitive to changes in significant assumptions, such as the discount rate, projected revenue and projected operating income that are forward-looking and affected by future economic and market conditions.

How We Addressed the Matter in Our Audit

We obtained an understanding, evaluated the design and tested the operating effectiveness of controls over the Company's annual goodwill impairment review process, including controls over management's review of the significant assumptions described above.

To test the estimated fair value of the Commercial Business reporting unit, we performed audit procedures that included, among others, assessing methodologies and testing the significant assumptions discussed above and the underlying data used by the Company in its analysis. We compared the significant assumptions to the reporting unit's historical results and third-party industry data. We performed sensitivity analyses of significant assumptions to evaluate the changes in the fair value of the reporting unit that would result from changes in the key assumptions. We involved valuation specialists to assist in our assessment of the methodology and significant assumptions (such as the discount rate), used by the Company. In addition, we tested management's reconciliation of the fair value of all reporting units to the market capitalization of the Company.

Valuation of health care costs payable

Description of the Matter

At December 31, 2020, the incurred but not reported ("IBNR") liabilities represented $6.1 billion of $7.9 billion of health care costs payable. As discussed in Note 1 to the financial statements, the Company's liability for health care costs payable includes estimated payments for (1) services rendered to members but not yet reported and (2) claims that have been reported but not yet paid, each as of the financial statement date (collectively, "IBNR"). The estimated IBNR liability is developed utilizing actuarial principles and assumptions that include historical and projected claim submission and processing patterns, historical and assumed medical cost trends, historical utilization of medical services, claim inventory levels, changes in membership and product mix, seasonality and other relevant factors to record the actuarial best estimate of health care costs payable. There is significant uncertainty inherent in determining management's actuarial best estimate of health care costs payable. In particular, the estimate is sensitive to the assumed completion factors and the assumed health care cost trend rates.

Auditing management's actuarial best estimate of IBNR reserves for health care costs payable for its products and services involved a high degree of subjectivity in evaluating management's assumptions used in the valuation process.

How We Addressed the Matter in Our Audit

We obtained an understanding, evaluated the design and tested the operating effectiveness of controls over the process for estimating IBNR reserves. This included, among others, controls over the completeness and accuracy of data used in the actuarial projections, the transfer of data between underlying source systems, and the review and approval processes that management has in place for the actuarial principles and assumptions used in estimating the health care costs payable.

To test IBNR reserves, our audit procedures included, among others, testing the completeness and accuracy of the underlying claim and membership data used in the calculation of IBNR reserves. We involved actuarial specialists to assist with our audit procedures, which included, among others, evaluating the methodologies applied by the Company in determining the actuarially determined liability, evaluating management's actuarial principles and assumptions used in their analysis based on historical claim experience, and independently calculating a range of reserve estimates for comparison to management's actuarial best estimate of the liability for health care costs payable. Additionally, we performed a review of the prior period liabilities for incurred but not paid claims to subsequent claims development.

/s/ Ernst & Young LLP

We have served as the Company's auditor since 2007.

Boston, Massachusetts
February 16, 2021

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

None.

Item 9A. Controls and Procedures.

Evaluation of disclosure controls and procedures

The Company's Chief Executive Officer and Chief Financial Officer, after evaluating the effectiveness of the design and operation of the Company's disclosure controls and procedures (as defined in Rules 13a-15 (f) and 15d-15(f) under the Securities Exchange Act of 1934) as of December 31, 2020, have concluded that as of such date the Company's disclosure controls and procedures were adequate and effective at a reasonable assurance level and designed to ensure that material information relating to the Company and its consolidated subsidiaries would be made known to such officers on a timely basis.

Management's report on internal control over financial reporting

Management is responsible for establishing and maintaining adequate internal control over financial reporting. The Company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of the Company's consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the Company's assets that could have a material effect on the Company's consolidated financial statements. In order to ensure the Company's internal control over financial reporting is effective, management regularly assesses such control and did so most recently for its financial reporting as of December 31, 2020.

Management conducted an assessment of the effectiveness of the Company's internal control over financial reporting based on the criteria established in *Internal Control-Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 Framework). This evaluation included review of the documentation, evaluation of the design effectiveness and testing of the operating effectiveness of controls. The Company's system of internal control over financial reporting is enhanced by periodic reviews by the Company's internal auditors, written policies and procedures and a written Code of Conduct adopted by CVS Health's Board of Directors, applicable to all employees of the Company. In addition, the Company has an internal Disclosure Committee, comprised of management from each functional area within the Company, which performs a separate review of disclosure controls and procedures. There are inherent limitations in the effectiveness of any system of internal control over financial reporting.

Based on management's assessment, management concluded that the Company's internal control over financial reporting is effective and provides reasonable assurance that assets are safeguarded and that the financial records are reliable for preparing financial statements as of December 31, 2020.

Ernst & Young LLP, the Company's independent registered public accounting firm, is appointed by CVS Health's Board of Directors and ratified by CVS Health's stockholders. They were engaged to render an opinion regarding the fair presentation of the Company's consolidated financial statements as well as conducting an audit of internal control over financial reporting. Their reports included in Item 8 of this Form 10-K are based upon audits conducted in accordance with the standards of the Public Company Accounting Oversight Board (United States).

Changes in internal control over financial reporting

There has been no change in the Company's internal control over financial reporting identified in connection with the evaluation required by paragraph (d) of Rule 13a-15 or Rule 15d-15 that occurred during the fourth quarter ended December 31, 2020 that has materially affected, or is reasonably likely to materially affect, the Company's internal control over financial reporting.

Item 9B. Other Information.

No events have occurred during the fourth quarter ended December 31, 2020 that would require disclosure under this item.

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

Information concerning the Executive Officers of CVS Health Corporation is included in Part I of this 10-K pursuant to General Instruction G to Form 10-K.

The sections of the Proxy Statement under the captions "Committees of the Board as of the Annual Meeting," "Code of Conduct," "Audit Committee Report," and "Biographies of our Incumbent Board Nominees" are incorporated herein by reference.

Item 11. Executive Compensation.

The sections of the Proxy Statement under the captions "Non-Employee Director Compensation" and "Executive Compensation and Related Matters," including "Letter from the Management Planning and Development Committee," "Compensation Committee Report," "Compensation Discussion and Analysis" and "Compensation of Named Executive Officers" are incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

The sections of the Proxy Statement under the captions "Share Ownership of Directors and Certain Executive Officers" and "Share Ownership of Principal Stockholders" are incorporated herein by reference. Those sections contain information concerning security ownership of certain beneficial owners and management and related stockholder matters.

The following table summarizes information about the registrant's common stock that may be issued upon the exercise of options, warrants and rights under all of the Company's equity compensation plans as of December 31, 2020:

	Number of securities to be issued upon exercise of outstanding options, warrants and rights [1] [2] (a)	Weighted average exercise price of outstanding options, warrants and rights (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in first column) [1] (c)
Equity compensation plans approved by stockholders [3]	33,944	$ 72.18	37,856
Equity compensation plans not approved by stockholders [4]	4,812	43.27	—
Total	38,756	$ 71.18	37,856

(1) Shares in thousands.

(2) Consists of: (i) 21,796 shares of common stock underlying outstanding options, (ii) 779 shares of common stock issuable upon the exercise of outstanding stock appreciation rights ("SARs") and (iii) 16,181 shares of common stock issuable on the vesting of outstanding restricted stock units, deferred stock units and performance stock units, assuming target level performance in the case of performance stock units. The number of shares included with respect to outstanding SARs is the number of shares of CVS Health common stock that would have been issued had the SARs been exercised based on the closing price per share of CVS Health common stock on December 31, 2020, as reported on the NYSE, which was $68.30.

(3) Consists of the CVS Health 2017 Incentive Compensation Plan.

(4) Consists of the Amended Aetna Inc. 2010 Stock Incentive Plan (the "Aetna Stock Plan"). The Aetna Stock Plan expired on May 21, 2020, therefore there are no securities available for future issuance under this plan.

The Aetna Stock Plan was last approved by Aetna's shareholders at Aetna's 2017 Annual Meeting on May 19, 2017. The Company elected to continue to grant awards under the Aetna Stock Plan to employees of Aetna and its subsidiaries following the completion of the Aetna Acquisition. The Aetna Stock Plan was designed to promote the Company's interests and those of its stockholders and to further align the interests of stockholders and employees by tying awards to total return to stockholders, enabling plan participants to acquire additional equity interests in the Company and providing compensation opportunities dependent upon the Company's performance. The Aetna Stock Plan was not submitted to the Company's stockholders and expired on May 21, 2020. Under the Aetna Stock Plan, eligible participants could be granted stock options to purchase shares of

CVS Health common stock, SARs, time-vesting and/or performance-vesting incentive stock or incentive units and other stock-based awards.

Item 13. Certain Relationships and Related Transactions, and Director Independence.

The sections of the Proxy Statement under the captions “Independence Determinations for Directors” and “Related Person Transaction Policy” are incorporated herein by reference.

Item 14. Principal Accountant Fees and Services.

The section of the Proxy Statement under the caption “Item 2: Ratification of Appointment of Independent Registered Public Accounting Firm for 2021” is incorporated herein by reference.

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PART IV

Item 15. Exhibits, Financial Statement Schedules.

The following documents are filed as part of this 10-K:

1. Financial Statements. See “Index to Consolidated Financial Statements” in Item 8 of this 10-K.

2. Financial Statement Schedules. All financial statement schedules are omitted because they are not applicable, not required under the instructions, or the information is included in the consolidated financial statements or related notes.

3. Exhibits. The exhibits listed in the “Index to Exhibits” in this Item 15 are filed or incorporated by reference as part of this 10-K. Exhibits marked with an asterisk (*) are management contracts or compensatory plans or arrangements. Exhibits other than those listed are omitted because they are not required to be listed or are not applicable. Pursuant to Item 601(b)(4)(iii) of Regulation S-K, the Registrant hereby agrees to furnish to the Securities and Exchange Commission a copy of any omitted instrument that is not required to be listed.

INDEX TO EXHIBITS

Exhibit	Description
2	**Plan of acquisition, reorganization, arrangement, liquidation or succession**
2.1	Agreement and Plan of Merger, dated as of May 20, 2015, among CVS Pharmacy, Inc., Tree Merger Sub, Inc. and Omnicare, Inc. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K filed May 21, 2015).
2.2	Master Transaction Agreement dated as of October 22, 2017, by and between Aetna Inc. and Hartford Life and Accident Insurance Company (incorporated by reference to Exhibit 2.3 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
2.3	Agreement and Plan of Merger, dated as of December 3, 2017, among CVS Health Corporation, Hudson Merger Sub Corp. and Aetna Inc. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K filed December 5, 2017).
3	**Articles of Incorporation and Bylaws**
3.1	Restated Certificate of Incorporation of the Registrant dated June 4, 2018 (incorporated by reference to Exhibit 3.1C of Registrant's Current Report on Form 8-K filed June 5, 2018).
3.2	By-Laws of the Registrant, as amended and restated July 8, 2020 (incorporated by reference to Exhibit 3.1 to the Registrant's Current Report on Form 8-K filed July 10, 2020).
4	**Instruments defining the rights of security holders, including indentures**
4.1	Specimen common stock certificate (incorporated by reference to Exhibit 4.1 to the Registration Statement of the Registrant ((then known as CVS Corporation) as successor to Melville Corporation) on Form 8-B filed November 4, 1996).
4.2	Senior Indenture dated August 15, 2006, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed August 15, 2006).
4.3	Form of the Registrant's 2021 Floating Rate Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.4	Form of the Registrant's 2021 Note (incorporated by reference to Exhibit 4.4 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.5	Form of the Registrant's 2023 Note (incorporated by reference to Exhibit 4.5 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.6	Form of the Registrant's 2025 Note (incorporated by reference to Exhibit 4.6 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.7	Form of the Registrant's 2028 Note (incorporated by reference to Exhibit 4.7 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.8	Form of the Registrant's 2038 Note (incorporated by reference to Exhibit 4.8 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.9	Form of the Registrant's 2048 Note (incorporated by reference to Exhibit 4.9 to the Registrant's Current Report on Form 8-K filed March 12, 2018).

4.10	Form of the Registrant's 2024 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed August 15, 2019).
4.11	Form of the Registrant's 2026 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed August 15, 2019).
4.12	Form of the Registrant's 2029 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed August 15, 2019).
4.13	Form of the Registrant's 2027 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).
4.14	Form of the Registrant's 2030 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).
4.15	Form of the Registrant's 2040 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).
4.16	Form of the Registrant's 2050 Note (incorporated by reference to Exhibit 4.4 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).
4.17	Form of the Registrant's 2027 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed on August 21, 2020).
4.18	Form of the Registrant's 2030 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed on August 21, 2020).
4.19	Form of the Registrant's 2040 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed on August 21, 2020).
4.20	Form of the Registrant's 2027 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed on December 16, 2020).
4.21	Form of the Registrant's 2031 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed on December 16, 2020).
4.22	Material terms of outstanding securities that are registered under Section 12 of the 1934 Act as required by Item 202(a)-(d) and (f) of Regulation S-K.
10	**Material Contracts**
10.1	Five Year Credit Agreement, dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017).
10.2	Amendment No. 1 to Five Year Credit Agreement dated as of December 15, 2017, to the Five Year Credit Agreement dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.3 to the Registrant's Current Report on Form 8-K filed December 19, 2017).
10.3	Amendment No. 2 to Five Year Credit Agreement dated as of May 17, 2018, to the Five Year Credit Agreement dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018).
10.4	Amendment No. 3, dated as of May 16, 2019, to the Five Year Credit Agreement dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.4 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.5	Five Year Credit Agreement dated as of May 17, 2018, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018).
10.6	Amendment No. 1, dated as of May 16, 2019, to the Five Year Credit Agreement dated as of May 17, 2018, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.3 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.7	364-Day Credit Agreement dated as of May 13, 2020 by and among the Registrant, the lenders party thereto, Barclays Bank PLC and JPMorgan Chase Bank, N.A., as Co-Syndication Agents, Goldman Sachs Bank USA, and Wells Fargo Bank, National Association, as Co-Documentation Agents, and Bank of America, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2020).
10.8	Five Year Credit Agreement dated as of May 16, 2019 by and among the Registrant, the lenders party thereto and Bank of America, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.2 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).

10.9*	The Registrant's Supplemental Retirement Plan I for Select Senior Management, as amended and restated as of December 31, 2008 (incorporated by reference to Exhibit 10.6 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2009).
10.10*	Form of Enterprise Non-Competition, Non-Disclosure and Developments Agreement between the Registrant and certain of the Registrant's executive officers (incorporated by reference to Exhibit 10.25 of the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013).
10.11*	The Registrant's Deferred Stock Compensation Plan, as amended and restated (incorporated by reference to Exhibit 10.11 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2019).
10.12*	The Registrant's 2007 Employee Stock Purchase Plan, as amended (incorporated by reference to Exhibit 99.2 to the Registrant's Registration Statement on Form S-8 filed May 19, 2020).
10.13*	Universal 409A Definition Document, as amended (incorporated by reference to Exhibit 10.28 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
10.14*	The Registrant's Deferred Compensation Plan, as amended and restated (incorporated by reference to Exhibit 10.14 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2019).
10.15*	The Registrant's Partnership Equity Program, as amended (incorporated by reference to Exhibit 10.25 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.16*	The Registrant's Performance-Based Restricted Stock Unit Plan, as amended (incorporated by reference to Exhibit 10.27 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.17*	The Registrant's 2017 Incentive Compensation Plan, as amended (incorporated by reference to Exhibit 99.1 to the Registrant's Registration Statement on Form S-8 filed May 19, 2020).
10.18*	The Registrant's Executive Incentive Plan, as amended (incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017).
10.19*	The Registrant's Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017).
10.20*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.29 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.21*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.30 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.22*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.23*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax) (incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.24*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Post-Tax) (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.25*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018).
10.26*	Form of Performance Stock Unit Agreement (LTIP) - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018).
10.27*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended September 30, 2020).
10.28*	The Registrant's Management Incentive Plan (incorporated by reference to Exhibit 10.27 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2019).
10.29*	The Registrant's Severance Plan for Non-Store Employees amended as of November 28, 2018 (incorporated by reference to Exhibit 10.37 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.30*	The Registrant's Performance-Based Restricted Stock Unit Program, as amended (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.31*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.39 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).

10.32*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.40 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.33*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.41 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.34*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax) (incorporated by reference to Exhibit 10.42 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.35*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Post-Tax) (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013).
10.36*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.5 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.37*	Amended and Restated Employment Agreement between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2008).
10.38*	Amendment dated as of December 21, 2012 to the Amended and Restated Employment Agreement between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012).
10.39*	Form of Non-Qualified Stock Option Agreement - Annual Grant between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.37 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.40*	Form of Restricted Stock Unit Agreement - Annual Grant between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.41*	Amendment dated January 22, 2015 to Nonqualified Stock Option Agreements between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed January 23, 2015).
10.42*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.43*	Change in Control Agreement effective as of July 19, 2010 between the Registrant and Eva Boratto (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2019).
10.44*	Restrictive Covenant Agreement dated June 21, 2019 between the Registrant and Eva Boratto (incorporated by reference to Exhibit 10.48 to the registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2019).
10.45*	Change in Control Agreement dated December 22, 2008 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012).
10.46*	Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.34 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012).
10.47*	Restricted Stock Unit Agreement - Annual Grant dated April 1, 2016 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.44 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.48*	Restrictive Covenant Agreement dated May 20, 2016 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.45 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.49*	Change in Control Agreement dated October 1, 2012 between the Registrant and Thomas Moriarty (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2015).
10.50*	Restrictive Covenant Agreement dated July 8, 2019 between the Registrant and Thomas Moriarty (incorporated by reference to Exhibit 10.56 of the Registrant's Annual Report on form 10-K for the fiscal year ended December 31, 2019).
10.51*	Amended and Restated Employment Agreement dated November 5, 2020 between the Registrant and Karen S. Lynch.

10.52*	Restrictive Covenant Agreement dated November 6, 2020 between the Registrant and Karen S. Lynch.
10.53*	Descriptions of certain arrangements not embodied in formal documents as described under the heading "Non-Employee Director Compensation" are incorporated herein by reference to the Proxy Statement (when filed).
21	**Subsidiaries of the registrant**
21.1	Subsidiaries of CVS Health Corporation.
23	**Consents of experts and counsel**
23.1	Consent of Ernst & Young LLP.
31	**Rule 13a-14(a)/15d-14(a) Certifications**
31.1	Certification by the Chief Executive Officer.
31.2	Certification by the Chief Financial Officer.
32	**Section 1350 Certifications**
32.1	Certification by the Chief Executive Officer.
32.2	Certification by the Chief Financial Officer.
101	**Interactive Data File**
101	The following materials from the CVS Health Corporation Annual Report on Form 10-K for the fiscal year ended December 31, 2020 formatted in Inline XBRL: (i) the Consolidated Statements of Operations, (ii) the Consolidated Statements of Comprehensive Income (Loss), (iii) the Consolidated Balance Sheets, (iv) the Consolidated Statements of Cash Flows, (v) the Consolidated Statements of Shareholders' Equity and (vi) the related Notes to Consolidated Financial Statements. The instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
104	
104	Cover Page Interactive Data File - The cover page from the Company's Annual Report on Form 10-K for the year ended December 31, 2020, formatted in Inline XBRL (included as Exhibit 101).

Item 16. Form 10-K Summary.

None.

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SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

CVS HEALTH CORPORATION

Date: February 16, 2021 By: /s/ EVA C. BORATTO

Eva C. Boratto

Executive Vice President and Chief Financial Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title(s)	Date
/s/ FERNANDO AGUIRRE **Fernando Aguirre**	Director	February 16, 2021
/s/ C. DAVID BROWN II **C. David Brown II**	Director	February 16, 2021
/s/ EVA C. BORATTO **Eva C. Boratto**	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 16, 2021
/s/ JAMES D. CLARK **James D. Clark**	Senior Vice President - Controller and Chief Accounting Officer (Principal Accounting Officer)	February 16, 2021
/s/ ALECIA A. DECOUDREAUX **Alecia A. DeCoudreaux**	Director	February 16, 2021
/s/ NANCY-ANN M. DEPARLE **Nancy-Ann M. DeParle**	Director	February 16, 2021
/s/ DAVID W. DORMAN **David W. Dorman**	Chair of the Board and Director	February 16, 2021
/s/ ROGER N. FARAH **Roger N. Farah**	Director	February 16, 2021
/s/ ANNE M. FINUCANE **Anne M. Finucane**	Director	February 16, 2021
/s/ EDWARD J. LUDWIG **Edward J. Ludwig**	Director	February 16, 2021
/s/ KAREN S. LYNCH **Karen S. Lynch**	President and Chief Executive Officer (Principal Executive Officer) and Director	February 16, 2021
/s/ LARRY J. MERLO **Larry J. Merlo**	Director	February 16, 2021
/s/ JEAN-PIERRE MILLON **Jean-Pierre Millon**	Director	February 16, 2021
/s/ MARY L. SCHAPIRO **Mary L. Schapiro**	Director	February 16, 2021
/s/ WILLIAM C. WELDON **William C. Weldon**	Director	February 16, 2021
/s/ TONY L. WHITE **Tony L. White**	Director	February 16, 2021

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2019

or

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

For the transition period from _____ to_____

Commission file number: 001-01011

cvshealtha23.jpg

CVS HEALTH CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: **(401) 765-1500**

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

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, par value $0.01 per share	CVS	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.	☑	Yes	☐	No
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.	☐	Yes	☑	No
Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.	☑	Yes	☐	No
Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files).	☑	Yes	☐	No

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

Large accelerated filer	☑	Accelerated filer	☐
	☐	Smaller reporting company	☐

Non-accelerated filer

			Emerging growth company	☐
If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act.				☐
Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act).	☐	Yes	☑	No

The aggregate market value of the registrant's common stock held by non-affiliates was approximately $70,617,679,934 as of June 28, 2019, based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be affiliates of the registrant.

As of February 12, 2020, the registrant had 1,304,159,680 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The following materials are incorporated by reference into this Form 10-K:

Information contained in the definitive proxy statement for CVS Health Corporation's 2020 Annual Meeting of Stockholders, to be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year ended December 31, 2019 (the "Proxy Statement"), is incorporated by reference in Parts III and IV to the extent described therein.

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Unless the context otherwise requires, references to the terms "we," "our" or "us" used throughout this Annual Report on Form 10-K (this "10-K") refer to CVS Health Corporation (a Delaware corporation) ("CVS Health") and its subsidiaries (collectively, the "Company"). References to competitors and other companies throughout this 10-K, including the information incorporated herein by reference, are for illustrative or comparison purposes only and do not indicate that these companies are the Company's or any segment's only competitors or closest competitors.

CAUTIONARY STATEMENT CONCERNING FORWARD-LOOKING STATEMENTS

The Private Securities Litigation Reform Act of 1995 (the "Reform Act") provides a "safe harbor" for forward-looking statements, so long as (1) those statements are identified as forward-looking, and (2) the statements are accompanied by meaningful cautionary statements that identify important factors that could cause actual results to differ materially from those discussed in the statement. We want to take advantage of these safe harbor provisions.

Certain information contained in this 10-K is forward-looking within the meaning of the Reform Act or SEC rules. This information includes, but is not limited to: "Outlook for 2020" of Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A") included in Item 7, "Quantitative and Qualitative Disclosures About Market Risk" included in Item 7A, "Government Regulation" included in Item 1, and "Risk Factors" included in Item 1A. In addition, throughout this 10-K and our other reports and communications, we use the following words or variations or negatives of these words and similar expressions when we intend to identify forward-looking statements:

· *Anticipates*	· *Believes*	· *Can*	· *Continue*	· *Could*
· *Estimates*	· *Evaluate*	· *Expects*	· *Explore*	· *Forecast*
· *Guidance*	· *Intends*	· *Likely*	· *May*	· *Might*
· *Outlook*	· *Plans*	· *Potential*	· *Predict*	· *Probable*
· *Projects*	· *Seeks*	· *Should*	· *View*	· *Will*

All statements addressing the future operating performance of CVS Health or any segment or any subsidiary and/or future events or developments, including statements relating to corporate strategy; revenue or adjusted revenue; operating income or adjusted operating income; earnings per share or adjusted earnings per share; Pharmacy Services segment business, sales results and/or trends and/or operations; Retail/LTC segment business, sales results and/or trends and/or operations; Health Care Benefits segment business, sales results and/or trends, medical cost trends, medical membership, Medicare Part D membership, medical benefit ratios and/or operations; incremental investment spending; interest expense; effective tax rate; weighted-average share count; cash flow from operations; net capital expenditures; cash available for debt repayment; integration synergies; net synergies; integration costs; enterprise modernization; transformation; leverage ratio; cash available for enhancing shareholder value; inventory reduction, turn rate and/or loss rate; debt ratings; the Company's ability to attract or retain customers and clients; store development and/or relocations; new product development; and the impact of industry and regulatory developments, as well as statements expressing optimism or pessimism about future operating results or events, are forward-looking statements within the meaning of the Reform Act.

Forward-looking statements rely on a number of estimates, assumptions and projections concerning future events, and are subject to a number of significant risks and uncertainties and other factors that could cause actual results to differ materially from those statements. Many of these risks and uncertainties and other factors are outside our control. Certain of these risks and uncertainties and other factors are described under "Risk Factors" included in Item 1A of this 10-K; these are not the only risks and uncertainties we face. There can be no assurance that the Company has identified all the risks that affect it. Additional risks and uncertainties not presently known to the Company or that the Company currently believes to be immaterial also may adversely affect the Company's businesses. If any of those risks or uncertainties develops into actual events, these events or circumstances could have a material adverse effect on the Company's businesses, operating results, cash flows, financial condition and/or stock price, among other effects.

You should not put undue reliance on forward-looking statements. Any forward-looking statement speaks only as of the date of this 10-K, and we disclaim any intention or obligation to update or revise forward-looking statements, whether as a result of new information, future events, uncertainties or otherwise.

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PART I

Item 1. Business.

Overview

CVS Health Corporation ("CVS Health"), together with its subsidiaries (collectively, the "Company," "we," "our" or "us"), is the nation's premier health innovation company helping people on their path to better health. Whether in one of its pharmacies or through its health services and plans, CVS Health is pioneering a bold new approach to total health by making quality care more affordable, accessible, simple and seamless. CVS Health is community-based and locally focused, engaging consumers with the care they need when and where they need it. The Company has approximately 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 105 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year and expanding specialty pharmacy services. CVS Health also serves an estimated 37 million people through traditional, voluntary and consumer-directed health insurance products and related services, including expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

On November 28, 2018 (the "Aetna Acquisition Date"), the Company acquired Aetna Inc. ("Aetna") for a combination of cash and CVS Health stock (the "Aetna Acquisition"). The Company acquired Aetna to help improve the consumer health care experience by combining Aetna's health care benefits products and services with CVS Health's retail locations, walk-in medical clinics and integrated pharmacy capabilities with the goal of becoming the new, trusted front door to health care. Under the terms of the merger agreement, Aetna shareholders received $145.00 in cash and 0.8378 CVS Health shares for each Aetna share. The transaction valued Aetna at approximately $212 per share or approximately $70 billion. Including the assumption of Aetna's debt, the total value of the transaction was approximately $78 billion. The Company financed the cash portion of the purchase price through a combination of cash on hand and by issuing approximately $45 billion of new debt, including senior notes and term loans. For additional information, see Note 2 ''Acquisitions and Divestitures'' included in Item 8 of this 10-K.

On October 10, 2018, the Company and Aetna entered into a consent decree with the U.S. Department of Justice (the "DOJ") that allowed the Company's proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone PDPs. As part of the agreement reached with the DOJ, Aetna entered into a purchase agreement with a subsidiary of WellCare Health Plans, Inc. ("WellCare") for the divestiture of Aetna's standalone PDPs effective December 31, 2018. On November 30, 2018, the Company completed the sale of Aetna's standalone PDPs. The Company provided administrative services to, and retained the financial results of, the divested plans through 2019. Subsequent to 2019, the Company will no longer retain the financial results of the divested plans. Aetna's standalone PDPs had an aggregate of 2.5 million members as of December 31, 2019.

As a result of the Aetna Acquisition, the Company added the Health Care Benefits segment. Certain aspects of Aetna's operations, including products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, are included in the Company's Corporate/Other segment.

Effective for the first quarter of 2019, the Company realigned the composition of its segments to correspond with changes to its operating model and reflect how its Chief Operating Decision Maker reviews information and manages the business. As a result of this realignment, the Company's SilverScript® PDP moved from the Pharmacy Services segment to the Health Care Benefits segment. In addition, the Company moved Aetna's mail order and specialty pharmacy operations from the Health Care Benefits segment to the Pharmacy Services segment. Segment financial information has been retrospectively adjusted to reflect these changes. See Note 17 ''Segment Reporting'' included in Item 8 of this 10-K for segment financial information.

The Company has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/ Other.

Business Strategy

CVS Health's purpose of helping people on their path to better health guides the Company's approach to transforming the consumer health experience. The Company is working to create the most consumer-centric health

company by being consumer obsessed and pursuing its three strategic goals: be local, make it simple and improve health. These goals are embedded in the Company's four Enterprise priorities: growing and differentiating our businesses, delivering transformational products and services, creating a consumer-centric technology infrastructure and modernizing Enterprise functions and capabilities. The

Company believes its strategy of putting the consumer at the center of care will drive long-term sustainable value and place the Company at the forefront of the evolution of health care.

Pharmacy Services Segment

The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services, mail order pharmacy, specialty pharmacy and infusion services, clinical services, disease management services and medical spend management. The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Medicaid managed care ("Managed Medicaid") plans, plans offered on public health insurance exchanges ("Public Exchanges") and private health insurance exchanges ("Private Exchanges" and together with Public Exchanges, "Insurance Exchanges"), other sponsors of health benefit plans and individuals throughout the U.S. The Pharmacy Services segment includes retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services. During the year ended December 31, 2019, the Company's PBM filled or managed 2.0 billion prescriptions on a 30-day equivalent basis.

PBM Services

The Company dispenses prescription drugs directly through its mail order dispensing and specialty mail order pharmacies and through pharmacies in its retail network. All prescriptions processed by the Company are analyzed, processed and documented by the Company's proprietary prescription management systems. These systems provide essential features and functionality to allow plan members to utilize their prescription drug benefits. These systems also streamline the process by which prescriptions are processed by staff and network pharmacists by enhancing review of various items through automation, including plan eligibility, early refills, duplicate dispensing, appropriateness of dosage, drug interactions or allergies, over-utilization and potential fraud.

Plan Design Offerings and Administration
The Company administers pharmacy benefit plans for clients who contract with it to facilitate prescription drug coverage and claims processing for their eligible plan members. The Company assists its PBM clients in designing pharmacy benefit plans that help improve health outcomes while minimizing the costs to the client. The Company also assists PBM clients in monitoring the effectiveness of their plans through frequent, informal communications, the use of proprietary software, as well as through formal annual, quarterly and sometimes monthly performance reviews.

The Company makes recommendations to help PBM clients design benefit plans that promote the use of lower cost, clinically appropriate drugs and helps its PBM clients control costs by recommending plan designs that encourage the use of generic equivalents of brand name drugs when such equivalents are available. Clients also have the option, through plan design, to further lower their pharmacy benefit plan costs by setting different member payment levels for different products on their drug lists or "formularies," which helps guide members to choose lower cost alternatives through appropriate financial incentives.

Formulary Management
The Company utilizes an independent panel of doctors, pharmacists and other medical experts, referred to as the CVS Caremark National Pharmacy and Therapeutics Committee, to review and approve the selection of drugs that meet the Company's standards of safety and efficacy for inclusion on one of the Company's template formularies. The Company's formularies provide recommended products in numerous drug classes to help ensure member access to clinically appropriate drugs with alternatives within a class under the client's pharmacy benefit plan, while helping to drive the lowest net cost for clients that select one of the Company's formularies. To help improve clinical outcomes for members and clients, the Company conducts ongoing, independent reviews of all drugs, including those appearing on the formularies and generic equivalent products. Many of the Company's clients choose to adopt a template formulary offering as part of their plan design. Beginning in 2018, PBM clients were given new capabilities to offer real time benefits information for a member's specific plan design, provided digitally at the point of prescribing, at the pharmacy and directly to members.

Retail Pharmacy Network Management Services
The Company maintains a national network of more than 68,000 retail pharmacies, consisting of approximately 41,000 chain pharmacies (which includes CVS Pharmacy locations) and approximately 27,000 independent pharmacies, in the United States, including Puerto Rico, the District of Columbia, Guam and the U.S. Virgin Islands.

When a customer fills a prescription in a retail pharmacy, the pharmacy sends prescription data electronically to the Company from the point-of-sale. This data interfaces with the Company's proprietary prescription management systems, which verify relevant plan member data and eligibility, while also performing a drug utilization review to help evaluate clinical appropriateness and safety and confirming that the

pharmacy will receive payment for the prescription. The Company also offers a Performance program for non-Medicare customers. The Performance program may be applied to any network. It can be implemented with either the Company's broad, national network or with a managed network (as allowed by applicable laws and regulations). Under the program, high performing pharmacies are eligible to receive an incremental positive performance payment. The program aligns with key Healthcare Effectiveness Data Information Set measures and is funded by client fees.

Mail Order Pharmacy Services
The Pharmacy Services segment operates mail order dispensing pharmacies in the United States. Plan members or their prescribers submit prescriptions or refill requests, primarily for maintenance medications, to these pharmacies, and staff pharmacists review these prescriptions and refill requests with the assistance of the Company's prescription management systems. This review may involve communications with the prescriber and, with the prescriber's approval when required, can result in generic substitution, therapeutic interchange or other actions designed to help reduce cost and/or improve quality of treatment. The Company's mail order dispensing pharmacies have been awarded Mail Service Pharmacy accreditation from URAC, a health care accrediting organization that establishes quality standards for the health care industry.

Specialty Pharmacy and Infusion Services
The Pharmacy Services segment operates specialty mail order pharmacies, retail specialty pharmacy stores and branches for infusion and enteral nutrition services in the United States. These specialty mail order pharmacies are used for delivery of advanced medications to individuals with chronic or genetic diseases and disorders. The Company's specialty mail order pharmacies also have been awarded Specialty Pharmacy accreditation from URAC. Substantially all of the Company's specialty mail order pharmacies also have been accredited by the Joint Commission, which is an independent, not-for-profit organization that accredits and certifies health care programs and organizations in the United States.

Clinical Services
The Company offers multiple clinical programs and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner. These programs are primarily designed to promote better health outcomes and to help target inappropriate medication utilization and non-adherence to medication, each of which may result in adverse medical events that negatively affect member health and client pharmacy and medical spend. These programs include utilization management ("UM"), medication management, quality assurance, adherence and counseling programs to complement the client's plan design and clinical strategies. To help address prescription opioid abuse and misuse, the Company introduced an industry-leading UM approach that limits to seven days the supply of opioids dispensed for certain acute prescriptions for patients who are new to therapy, limits the daily dosage of opioids dispensed based on the strength of the opioid and requires the use of immediate-release formulations of opioids before extended-release opioids are dispensed. The Company's Pharmacy Advisor® program facilitates pharmacist counseling, both face-to-face and over the telephone, to help participating plan members with certain chronic diseases, such as diabetes and cardiovascular conditions, to identify gaps in care, adhere to their prescribed medications and manage their health conditions. The Company also has digital connectivity that helps to lower drug costs for patients by providing expanded visibility to lower cost alternatives through enhanced analytics and data sharing.

Disease Management Programs
The Company's clinical programs and services utilize advanced protocols and offer clients convenience in working with health care providers ("providers") and other third parties. The Company's utilization management program covers diseases such as rheumatoid arthritis, Parkinson's disease, seizure disorders and multiple sclerosis and is accredited by the National Committee for Quality Assurance ("NCQA"), a private, not-for-profit organization that evaluates, accredits and certifies a wide range of health care organizations.

Medical Benefit Management
The Company's NovoLogix® online preauthorization tool helps identify and capture cost savings opportunities for specialty drugs billed under the medical benefit by identifying outliers to appropriate dosages and costs, and helps to ensure clinically appropriate use of specialty drugs.

Pharmacy Services Information Systems

The majority of the Pharmacy Services segment's clients have migrated to a single claim adjudication platform. This platform incorporates architecture that centralizes the data generated from filling mail order prescriptions,

adjudicating retail pharmacy claims and delivering other solutions to PBM clients. The Health Engagement Engine® technology and proprietary clinical algorithms help connect the various parts of the Enterprise and serve an essential role in cost management and health improvement. This capability transforms pharmacy data into actionable interventions at key points of care, such as mail and specialty pharmacists, to help provide quality care.

Pharmacy Services Clients

The Company's Pharmacy Services clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D plans, Managed Medicaid plans and plans offered on Insurance Exchanges, other sponsors of health benefit plans and individuals located throughout the United States. Pharmaceuticals are provided to eligible members in benefit plans maintained by clients and utilize the Company's information systems, among other things, to help perform safety checks, drug interaction screening and identify opportunities for generic substitution. Substantially all of the Pharmacy Services segment's revenues are generated from dispensing and managing prescription drugs to eligible members in benefit plans maintained by clients. In 2018 and 2017, revenues from Aetna accounted for approximately 9.8% and 12.3%, respectively, of the Company's consolidated total revenues. On the Aetna Acquisition Date, Aetna became a wholly-owned subsidiary of CVS Health. Subsequent to the Aetna Acquisition Date, revenues from Aetna continue to be reported in the Pharmacy Services segment; however, these revenues are eliminated in the consolidated financial statements.

Pharmacy Services Seasonality

The majority of Pharmacy Services segment revenues are not seasonal in nature.

Pharmacy Services Competition

The Company believes the primary competitive factors in the pharmacy services industry include: (i) the ability to negotiate favorable discounts from drug manufacturers as well as to negotiate favorable discounts from, and access to, retail pharmacy networks; (ii) the ability to identify and apply effective cost management programs utilizing clinical strategies, including the development and utilization of preferred formularies; (iii) the ability to market PBM products and services; (iv) the commitment to provide flexible, clinically-oriented services to clients and be responsive to clients' needs; (v) the quality, scope and costs of products and services offered to clients and their members; and (vi) operational excellence in delivering services. The Pharmacy Services segment has a significant number of competitors (e.g., the Express Scripts business of Cigna Corporation, OptumRx, Prime Therapeutics, MedImpact, Humana and PillPack), offering PBM services, including large, national PBM companies, PBMs owned by large national health plans and smaller standalone PBMs.

Retail/LTC Segment

The Retail/LTC segment sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products, cosmetics and personal care products, provides health care services through its MinuteClinic® walk-in medical clinics and conducts long-term care pharmacy ("LTC") operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. As of December 31, 2019, the Retail/LTC segment operated approximately 9,900 retail locations, approximately 1,100 MinuteClinic locations as well as online retail pharmacy websites, LTC pharmacies and onsite pharmacies. During the year ended December 31, 2019, the Retail/LTC segment filled 1.4 billion prescriptions on a 30-day equivalent basis. For the year ended December 31, 2019, the Company dispensed approximately 26.6% of the total retail pharmacy prescriptions in the United States.

Retail/LTC Products and Services

A typical retail store sells prescription drugs and a wide assortment of high-quality, nationally advertised brand name and proprietary brand merchandise. Front store categories include over-the-counter drugs, beauty products, cosmetics and personal care products. LTC operations include distribution of prescription drugs and related consulting and ancillary services. The Company purchases merchandise from numerous manufacturers and distributors. The Company believes that competitive sources are readily available for substantially all of the products carried in its retail stores and the loss of any one supplier would not likely have a material effect on the Retail/LTC segment. The Company's MinuteClinic locations offer a variety of health care services.

Retail/LTC revenues by major product group are as follows:

	Percentage of Revenues		
	2019	2018	2017
Pharmacy [1]	76.7%	76.4%	75.0%
Front store and other [2]	23.3%	23.6%	25.0%
	100.0%	100.0%	100.0%

(1) Pharmacy includes LTC sales and sales in pharmacies within Target Corporation stores.

(2) "Other" represents less than 5% of the "Front store and other" revenue category.

Pharmacy
Pharmacy revenues represented approximately three-fourths of Retail/LTC segment revenues in each of 2019, 2018 and 2017. The Company believes that retail pharmacy operations will continue to represent a critical part of the Company's business due to industry demographics, e.g., an aging American population consuming a greater number of prescription drugs, prescription drugs being used more often as the first line of defense for managing illness, the introduction of new pharmaceutical products, and Medicare Part D growth. The Company believes the retail pharmacy business benefits from investment in both people and technology, as well as innovative collaborations with health plans, PBMs and providers. Given the nature of prescriptions, consumers want their prescriptions filled accurately by professional pharmacists using the latest tools and technology, and ready when promised. Consumers also need medication management programs and better information to help them get the most out of their health care dollars. To assist consumers with these needs, the Company has introduced integrated pharmacy health care services that provide an earlier, easier and more effective approach to engaging consumers in behaviors that can help lower costs, improve health and save lives.

Front Store
Front store revenues reflect the Company's strategy of innovating with new and unique products and services, using innovative personalized marketing and adjusting the mix of merchandise to match customers' needs and preferences. A key component of the front store strategy is the ExtraCare® card program, which is one of the largest and most successful retail loyalty programs in the United States. The ExtraCare program allows the Company to balance marketing efforts so it can reward its best customers by providing them with automatic sale prices, customized coupons, ExtraBucks® rewards and other benefits. The Company also offers a subscription-based membership program, CarePass®, under which members are entitled to a suite of benefits delivered over the course of the subscription period, as well as a promotional reward that can be redeemed for future goods and services. The Company continues to launch and enhance new and exclusive brands to create unmatched offerings in beauty products and deliver other unique product offerings, including a full range of high-quality CVS Health and other proprietary brand products that are only available through CVS stores. The Company currently carries approximately 7,000 CVS Health and proprietary brand products, which accounted for approximately 22% of front store revenues during 2019.

MinuteClinic
As of December 31, 2019, the Company operated approximately 1,100 MinuteClinic locations in the United States. The clinics are staffed by nurse practitioners and physician assistants who utilize nationally established guidelines to deliver a variety of health care services. Payors value these clinics because they provide convenient, high-quality, cost-effective care, in many cases offering an attractive alternative to more expensive sites of care. Visits paid for by employers, health insurers or other third parties accounted for approximately
92% of MinuteClinic's total revenues in 2019. MinuteClinic is collaborating with the Pharmacy Services and Health Care Benefits segments to help meet the needs of CVS Caremark's client plan members and the Company's health plan members by offering programs that can improve member health and lower costs. MinuteClinic is now affiliated with more than 90 major health systems and continues to build a platform that supports primary care.

Long-term Care Pharmacy Operations
The Retail/LTC segment provides LTC pharmacy services through the Omnicare® business. Omnicare's customers consist of skilled nursing facilities, assisted living facilities, independent living communities, hospitals, correctional facilities, and other health care service providers. The Company provides pharmacy consulting, including monthly patient drug therapy evaluations, to assist in compliance with state and federal regulations and provide proprietary

clinical and health management programs. It also provides pharmaceutical case management services for retirees, employees and dependents who have drug benefits under corporate-sponsored health care programs.

Onsite Pharmacies
The Company also operates a limited number of pharmacies located at client sites, which provide certain health plan members and customers with a convenient alternative for filling their prescriptions.

Retail Store Development

The addition of new retail locations has played, and will continue to play, a key role in the Company's continued growth and success. The Company's store development program focuses on three areas: entering new service areas, adding stores within existing service areas and relocating stores to more convenient sites. During 2019, the Company opened approximately 100 new retail locations, relocated approximately 25 stores, converted approximately 50 stores into HealthHUB® locations and closed approximately 130 locations. HealthHUBs are stores with a redesigned format that provide enhanced services, offer a care concierge and focus on health and wellness products. HealthHUBs are designed to meet consumer needs and improve the customer experience by providing care that complements physician practices and hospital systems, enabling improved health outcomes and reducing overall health care costs. The Company expects to continue HealthHUB conversions through 2021. During the last five years, the Company opened approximately 790 new and relocated locations, and acquired approximately 1,810 locations, including the pharmacies acquired from Target Corporation ("Target") in 2015. The Company believes that continuing to assess the appropriateness of its store base and locate retail stores in more accessible locations are essential components of competing effectively in the current health care environment. As a result, the Company believes that its store development program is an integral part of its ability to meet the needs of customers and maintain its leadership position in the retail pharmacy marketplace given the changing health care landscape.

Retail/LTC Information Systems

The Company has continued to invest in information systems to enable it to deliver exceptional customer service, enhance safety and quality, and expand patient care services while lowering operating costs. The proprietary WeCARE Workflow supports pharmacy teams by prioritizing work to meet customer expectations, facilitating prescriber outreach, and seamlessly integrating clinical programs. This solution delivers improved efficiency and enhances the customer experience, as well as providing a framework to accommodate the evolution of pharmacy practice and the expansion of clinical programs. The Health Engagement Engine technology and proprietary clinical algorithms enable the Company to help identify opportunities for pharmacists to deliver face-to-face counseling regarding patient health and safety matters, including medication adherence issues, gaps in care and management of certain chronic health conditions. The Company's digital strategy is to empower the consumer to navigate their pharmacy experience and manage their condition through integrated online and mobile solutions that offer utility and convenience. The Company's LTC digital technology suite, Omniview®, improves the efficiency of customers' operations with tools that include executive dashboards, pre-admission pricing, electronic ordering of prescription refills, proof-of-delivery tracking, access to patient profiles, receipt and management of facility bills, and real-time validation of Medicare Part D coverage, among other capabilities.

Retail/LTC Customers

The success of the Retail/LTC segment's businesses is dependent upon the Company's ability to establish and maintain contractual relationships with pharmacy benefit managers and other payors on acceptable terms. Substantially all of the Retail/LTC segment's pharmacy revenues are derived from pharmacy benefit managers, managed care organizations, government funded health care programs, commercial employers and other third party payors. No single Retail/LTC payor accounted for 10% or more of the Company's consolidated total revenues in 2019, 2018 or 2017.

Retail/LTC Seasonality

The majority of Retail/LTC segment revenues, particularly pharmacy revenues, generally are not seasonal in nature. However, front store revenues tend to be higher during the December holiday season. In addition, both pharmacy and front store revenues are affected by the timing and severity of the cough, cold and flu season. Uncharacteristic or extreme weather conditions also can adversely affect consumer shopping patterns and Retail/LTC revenues, expenses and operating results.

Retail/LTC Competition

The retail pharmacy business is highly competitive. The Company believes that it competes principally on the basis of: (i) store location and convenience, (ii) customer service and satisfaction, (iii) product selection and variety, and (iv) price. In the areas it serves, the Company competes with other drugstore chains (e.g., Walgreens and Rite Aid), supermarkets, discount retailers (e.g., Wal-Mart), independent pharmacies, restrictive pharmacy networks,

membership clubs, internet companies, and retail health clinics (including urgent care centers), as well as mail order dispensing pharmacies.

LTC pharmacy services are highly regional or local in nature, and within a given geographic area of operation, highly competitive. The Company's largest LTC pharmacy competitor nationally is PharMerica. The Company also competes with

numerous local and regional institutional pharmacies, pharmacies owned by long-term care facilities and local retail pharmacies. Some states have enacted "freedom of choice" or "any willing provider" requirements as part of their state Medicaid programs or in separate legislation, which may increase the competition that the Company faces in providing services to long-term care facility residents in these states.

Health Care Benefits Segment

The Health Care Benefits segment is one of the nation's leading diversified health care benefits providers, serving an estimated 37 million people as of December 31, 2019. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make more informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental and behavioral health plans, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services, workers' compensation administrative services and health information technology ("HIT") products and services. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers, governmental units, government-sponsored plans, labor groups and expatriates. For periods prior to November 28, 2018 (the Aetna Acquisition Date), the Health Care Benefits segment was comprised of the Company's SilverScript PDP business.

Health Care Benefits Products and Services

The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk of medical and dental care costs) as "ASC." Health Care Benefits products and services consist of the following:

- *Commercial Medical*: The Health Care Benefits segment offers point-of-service ("POS"), preferred provider organization ("PPO"), health maintenance organization ("HMO") and indemnity benefit ("Indemnity") plans. Commercial medical products also include health savings accounts ("HSAs") and consumer-directed health plans that combine traditional POS or PPO and/or dental coverage, subject to a deductible, with an accumulating benefit account (which may be funded by the plan sponsor and/or the member in the case of HSAs). Principal products and services are targeted specifically to large multi-site national, mid-sized and small employers, individual insureds and expatriates. The Company offers medical stop loss insurance coverage for certain employers who elect to self-insure their health benefits. Under medical stop loss insurance products, the Company assumes risk for costs associated with large individual claims and/or aggregate loss experience within an employer's plan above a pre-set annual threshold.

- *Government Medical*: In select geographies, the Health Care Benefits segment offers Medicare Advantage plans, Medicare Supplement plans and prescription drug coverage for Medicare beneficiaries; participates in Medicaid and subsidized Children's Health Insurance Programs ("CHIP"); and participates in demonstration projects for members who are eligible for both Medicare and Medicaid ("Duals"). These Government Medical products are further described below:

    - *Medicare Advantage:* Through annual contracts with the U.S. Centers for Medicare & Medicaid Services ("CMS"), the Company offers HMO and PPO products for eligible individuals in certain geographic areas through the Medicare Advantage program. Members typically receive enhanced benefits over traditional fee-for-service Medicare coverage ("Original Medicare"), including reduced cost-sharing for preventive care, vision and other services. The Company offered network-based HMO and/or PPO plans in 1,416 counties in 45 states and Washington, D.C. in 2019. The Company has expanded to 1,680 counties in 45 states and Washington, D.C. for 2020. For certain qualifying employer groups, the Company offers Medicare PPO products nationally. When combined with the Company's PDP product, these national PPO plans form an integrated national Insured Medicare product for employers that provides medical and pharmacy benefits.

    - *Medicare PDP:* The Company is a national provider of drug benefits under the Medicare Part D prescription drug program. All Medicare eligible individuals are eligible to participate in this voluntary prescription drug plan. Members typically receive coverage for certain prescription drugs, usually subject to a deductible, co-insurance and/or co-payment. On November 30, 2018, the Company completed the sale of Aetna's standalone PDPs to WellCare effective December 31, 2018.

The Company provided administrative services to, and retained the financial results of, the divested plans through 2019. Subsequent to 2019, the Company will no longer retain the financial results of the divested plans.

- *Medicare Supplement:* For certain Medicare eligible members, the Company offers supplemental coverage for certain health care costs not covered by Original Medicare. The products included in the Medicare Supplement portfolio help to cover some of the gaps in Original Medicare, and include coverage for Medicare deductibles and

coinsurance amounts. The Company offered a wide selection of Medicare Supplement products in 49 states and Washington, D.C. in 2019.

- *Medicaid and CHIP:* The Company offers health care management services to individuals eligible for Medicaid and CHIP under multi-year contracts with government agencies in various states that are subject to annual appropriations. CHIP are state-subsidized insurance programs that provide benefits for families with uninsured children. The Company offered these services on an Insured or ASC basis in 16 states in 2019.

- *Duals:* The Company provides health coverage to beneficiaries who are dually eligible for both Medicare and Medicaid coverage. These members must meet certain income and resource requirements in order to qualify for this coverage. The Company coordinates 100% of the care for these members and may provide them with additional services in order to manage their health care costs.

- *Specialty*: The Health Care Benefits segment has a portfolio of additional health products and services that complement its medical products such as dental plans, behavioral health and employee assistance products, provider network access and vision products and workers' compensation administrative services.

- *Transformative Products and Services*: The Company has a portfolio of transformative products and services aimed at creating a holistic and integrated approach to individual health and wellness. These products and services complement the Commercial Medical and Government Medical products and aim to provide innovative solutions, create integrated experience offerings and enable enhanced care delivery to customers.

Health Care Benefits Provider Networks

The Company contracts with physicians, hospitals and other providers for services they provide to the Company's members. The Company uses a variety of techniques designed to help encourage appropriate utilization of medical services ("utilization") and maintain affordability of quality coverage. In addition to contracts with providers for negotiated rates of reimbursement, these techniques include creating risk sharing arrangements that align economic incentives with providers, the development and implementation of guidelines for the appropriate utilization of medical services and the provision of data to providers to enable them to improve health care quality. At December 31, 2019, the Company's underlying nationwide provider network had approximately 1.3 million participating providers, including over 706,000 primary care and specialist physicians and approximately 5,900 hospitals. Other providers in the Company's provider networks also include laboratory, imaging, urgent care and other freestanding health facilities.

Health Care Benefits Quality Assessment

CMS uses a 5-star rating system to monitor Medicare health care and drug plans and ensure that they meet CMS's quality standards. CMS uses this rating system to provide Medicare beneficiaries with a tool that they can use to compare the overall quality of care and level of customer service of companies that provide Medicare health care and drug plans. The rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management and overall customer satisfaction. See "Health Care Benefits Pricing" below in this Item 1 for further discussion of star ratings. The Company seeks Health Plan accreditation for Aetna HMO plans from the NCQA. Health care plans seeking accreditation must pass a rigorous, comprehensive review and must annually report on their performance.

Aetna Life Insurance Company ("ALIC"), a wholly-owned subsidiary of the Company, has received nationwide NCQA PPO Health Plan accreditation. As of December 31, 2019, all of the Company's Commercial HMO and all of ALIC's PPO members who were eligible participated in HMOs or PPOs that are accredited by the NCQA.

The Company's provider selection and credentialing/re-credentialing policies and procedures are consistent with NCQA and URAC, as well as state and federal, requirements. In addition, the Company is certified under the NCQA Credentials Verification Organization ("CVO") certification program for all certification options and has URAC CVO accreditation.

Quality assessment programs for contracted providers who participate in the Company's networks begin with the initial review of health care practitioners. Practitioners' licenses and education are verified, and their work history is collected by the Company or in some cases by the practitioner's affiliated group or organization. The Company

generally requires participating hospitals to be certified by CMS or accredited by the Joint Commission, the American Osteopathic Association, or Det Norske Veritas Healthcare.

The Company also offers quality and outcome measurement programs, quality improvement programs, and health care data analysis systems to providers and purchasers of health care services.

Health Care Benefits Information Systems

The Health Care Benefits segment currently operates and supports an end-to-end suite of information technology platforms to support member engagement, enrollment, health benefit administration, care management, service operations, financial reporting and analytics. The multiple platforms are supported by an integration layer to facilitate the transfer of real-time data. There is continued focus and investment in digital products to offer innovative solutions and a seamless experience to the Company's members through mobile and web channels. The Company is making concerted investments in emerging technology capabilities such as voice, artificial intelligence and robotics to further automate and improve the experience for all of its constituents. The Health Care Benefits segment is integrating with the Retail/LTC and Pharmacy Services segments to build Enterprise technology assets that will help guide our members through their health care journey, provide them a high level of service, enable healthier outcomes and encourage them to take next best actions to lead healthier lives.

Health Care Benefits Customers

Medical membership is dispersed throughout the United States, and the Company also serves medical members in certain countries outside the United States. The Company offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, many of which are available nationwide. Depending on the product, the Company markets to a range of customers including employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans, labor groups and expatriates.

For additional information on medical membership, see "Health Care Benefits Segment" in the Management's Discussion and Analysis of Financial Condition and Results of Operations (the "MD&A") included in Item 7 of this 10-K.

The Company markets both Commercial Insured and ASC products and services primarily to employers that sponsor the Company's products for the benefit of their employees and their employees' dependents. Frequently, larger employers offer employees a choice among coverage options, from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to the Company and, through payroll deductions, obtain reimbursement from employees for a percentage of the premiums that is determined by each employer. Some Health Care Benefits products are sold directly to employees of employer groups on a fully employee-funded basis. In some cases, the Company bills the covered individual directly.

The Company offers Insured Medicare coverage on an individual basis as well as through employer groups to their retirees. Medicaid and CHIP members are enrolled on an individual basis. The Company also offers Insured health care coverage to members who are dually-eligible for both Medicare and Medicaid.

Health Care Benefits products are sold through the Company's sales personnel; through independent brokers, agents and consultants who assist in the production and servicing of business; and through Private Exchanges. For large plan sponsors, independent consultants and brokers are frequently involved in employer health plan selection decisions and sales. In some instances, the Company may pay commissions, fees and other amounts to brokers, agents, consultants and sales representatives who place business with the Company. In certain cases, the customer pays the broker for services rendered, and the Company may facilitate that arrangement by collecting the funds from the customer and transmitting them to the broker. The Company supports marketing and sales efforts with an advertising program that may include television, radio, billboards, print media and social media, supplemented by market research and direct marketing efforts.

The U.S. federal government is a significant customer of the Health Care Benefits segment through contracts with CMS for coverage of Medicare-eligible individuals and federal employee-related benefit programs. Other than the contracts with CMS, the Health Care Benefits segment is not dependent upon a single customer or a few customers the loss of which would have a significant effect on the earnings of the segment. The loss of business from any one, or a few, independent brokers or agents would not have a material adverse effect on the earnings of the Health Care Benefits segment. In 2019, Health Care Benefits segment revenues from the federal government accounted for approximately 13% of the Company's consolidated total revenues. Contracts with CMS for coverage of Medicare-eligible individuals accounted for approximately 95% of the Company's revenues from the federal government in 2019. No single Health Care Benefits customer accounted for 10% or more of the Company's consolidated total revenues in 2018 or 2017.

Health Care Benefits Pricing

For Commercial Insured plans, contracts containing the pricing and other terms of the relationship are generally established in advance of the policy period and typically have a duration of one year. Fees under ASC plans are generally fixed for a period of one year.

Generally, a fixed premium rate is determined at the beginning of the policy period for Commercial Insured plans. The Company typically cannot recover unanticipated increases in health care and other benefit costs in the current policy period; however, it may consider prior experience for a product in the aggregate or for a specific customer, among other factors, in determining premium rates for future policy periods. Where required by state laws, premium rates are filed and approved by state regulators prior to contract inception. Future operating results could be adversely affected if the premium rates requested are not approved or are adjusted downward or their approval is delayed by state or federal regulators.

The Company has Medicare Advantage and PDP contracts with CMS to provide HMO, PPO and prescription drug coverage to Medicare beneficiaries in certain geographic areas. Under these annual contracts, CMS pays the Company a fixed per member (or "capitation") payment and/or a portion of the premium, both of which are based on membership and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed capitation payment or premium. PDP contracts also provide a risk-sharing arrangement with CMS to limit the Company's exposure to unfavorable expenses or benefit from favorable expenses. Amounts payable to the Company under the Medicare arrangements are subject to annual revision by CMS, and the Company elects to participate in each Medicare service area or region on an annual basis. Premiums paid to the Company for Medicare products are subject to federal government reviews and audits, which can result, and have resulted, in retroactive and prospective premium adjustments and refunds to the government and/or members. In addition to payments received from CMS, some of Medicare Advantage products and all PDP products require a supplemental premium to be paid by the member or sponsoring employer. In some cases these supplemental premiums are adjusted based on the member's income and asset levels. Compared to Commercial Medical products, Medicare contracts generate higher per member per month revenues and higher health care and other benefit costs.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA") ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star ratings." Plans must have a star rating of four or higher (out of five) to qualify for bonus payments. CMS released the Company's 2020 star ratings in October 2019. The Company's 2020 star ratings will be used to determine which of the Company's Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2021. Based on the Company's membership at December 31, 2019, 83% of the Company's Medicare Advantage members were in plans with 2020 star ratings of at least 4.0 stars, compared to 79% of the Company's Medicare Advantage members being in plans with 2019 star ratings of at least 4.0 stars based on the Company's membership at December 31, 2018.

Rates for Medicare Supplement products are regulated at the state level and vary by state and plan.

Under Insured Medicaid contracts, state government agencies pay the Company fixed monthly rates per member that vary by state, line of business and demographics; and the Company arranges, pays for and manages the health care services provided to Medicaid beneficiaries. These rates are subject to change by each state, and, in some instances, provide for adjustment for health risk factors. CMS requires these rates to be actuarially sound. The Company also receives fees from customers where it provides services under ASC Medicaid contracts. ASC Medicaid contracts generally are for periods of more than one year, and certain of them contain performance incentives and limited financial risk sharing with respect to certain medical, financial and operational metrics. Under these arrangements, performance is evaluated annually, with associated financial incentive opportunities, and financial risk share obligations are typically limited to a percentage of the fees otherwise payable to the Company. Payments to the Company under Medicaid contracts are subject to the annual appropriation process in the applicable state.

Under Duals contracts, the rate setting process is generally established by CMS in partnership with the state government agency participating in the demonstration project. Both CMS and the state government agency may seek premium and other refunds under certain circumstances, including if the Company fails to comply with CMS regulations or other contractual requirements.

The Company offers HMO and consumer-directed medical and dental plans to federal employees under the Federal Employees Health Benefits ("FEHB") Program and the Federal Employees Dental and Vision Insurance Program. Premium rates and fees

for those plans are subject to federal government review and audit, which can result, and have resulted, in retroactive and prospective premium and fee adjustments and refunds to the government and/or members.

Beginning in 2014, the ACA imposed significant new industry-wide fees, assessments and taxes, including an annual levy known as the Health Insurer Fee (the "HIF"). The HIF applies for 2020 and was temporarily suspended for 2019 and 2017. In December 2019, the HIF was repealed for calendar years after 2020. For additional information on the ACA fees, assessments and taxes, see Note 1 "Significant Accounting Policies" included in Item 8 of this 10-K. The Company's goal is to collect in premiums and fees where possible, or solve for, all of the ACA-related fees, assessments and taxes.

Health Care Benefits Seasonality

For periods prior to the Aetna Acquisition Date, the Health Care Benefits segment was comprised of the Company's SilverScript PDP business. The quarterly earnings and operating cash flows of the PDP business are impacted by the Medicare Part D benefit design and changes in the composition of PDP membership. The Medicare Part D standard benefit design results in coverage that varies with a member's cumulative annual out-of-pocket costs. The benefit design generally results in employers or other entities that sponsor the Company's products ("plan sponsors") sharing a greater portion of the responsibility for total prescription drug costs in the early part of the year. As a result, the PDP pay percentage or benefit ratio generally decreases and operating income generally increases as the year progresses. For periods subsequent to the Aetna Acquisition, the Health Care Benefits segment's quarterly operating income progression is also impacted by (i) the seasonality of benefit costs which generally increase during the year as Insured members progress through their annual deductibles and out-of-pocket expense limits and (ii) the seasonality of operating expenses which are generally the highest during the fourth quarter due primarily to spending to support readiness for the start of the upcoming Medicare plan year and marketing associated with Medicare annual enrollment.

Health Care Benefits Competition

The health care benefits industry is highly competitive, primarily due to a large number of for-profit and not-for-profit competitors, competitors' marketing and pricing and a proliferation of competing products, including new products that are continually being introduced into the marketplace. New entrants into the marketplace, as well as consolidation within the industry, have contributed to and are expected to intensify the competitive environment. In addition, the rapid pace of change as the industry evolves towards a consumer-focused retail marketplace, including Insurance Exchanges, and the increased use of technology to interact with members, providers and customers, increase the risks the Company currently faces from new entrants and disruptive actions by existing competitors compared to prior periods.

The Company believes that the significant factors that distinguish competing health plans include the perceived overall quality (including accreditation status), quality of service, comprehensiveness of coverage, cost (including premium rates, provider discounts and member out-of-pocket costs), product design, financial stability and ratings, breadth and quality of provider networks, ability to offer different provider network options, providers available in such networks, and quality of member support and care management programs. The Company believes that it is competitive on each of these factors. The Company's ability to increase the number of persons covered by its health plans or to increase Health Care Benefits segment revenues is affected by its ability to differentiate itself from its competitors on these factors. Competition may also affect the availability of services from health care providers, including primary care physicians, specialists and hospitals.

Insured products compete with local and regional health care benefits plans, health care benefits and other plans sponsored by other large commercial health care benefit insurance companies, health system owned health plans, new entrants into the marketplace and numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association. The largest competitor in Medicare products is Original Medicare. Additional Health Care Benefits segment competitors include other types of medical and dental provider organizations, various specialty service providers (including PBM services providers), health care consultants, financial services companies, integrated health care delivery organizations (networks of providers who also coordinate administrative services for and assume insurance risk of their members), third party administrators ("TPAs"), HIT companies and, for certain plans, programs sponsored by the federal or state governments. Emerging competitors include start up health care benefits plans, technology companies, provider-owned health plans, new joint ventures (including not-for-profit joint ventures among firms from multiple industries), technology firms, financial services firms that are distributing competing products on their proprietary Private Exchanges, and

consulting firms that are distributing competing products on their proprietary Private Exchanges, as well as non-traditional distributors such as retail companies. The Company's ability to increase the number of persons enrolled in Insured Commercial Medical products also is affected by the desire and ability of employers to self-fund their health coverage.

The Health Care Benefits segment's ASC plans compete primarily with other large commercial health care benefit companies, numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association and TPAs.

The Health Care Benefits segment's international products compete with local, global and U.S.-based health plans and commercial health care benefit insurance companies, many of whom are licensed in more geographies and have a longer operating history, better brand recognition and greater marketplace presence in one or more geographies.

The provider solutions and HIT marketplaces and products are evolving rapidly. The Company competes for provider solutions and HIT business with other large health plans and commercial health care benefit insurance companies as well as information technology companies and companies that specialize in provider solutions and HIT. Many information technology product competitors have longer operating histories, better brand recognition, greater marketplace presence and more experience in developing innovative products.

In addition to competitive pressures affecting the Company's ability to obtain new customers or retain existing customers, the Health Care Benefits segment's medical membership has been and may continue to be adversely affected by adverse and/or uncertain economic conditions and reductions in workforce by existing customers due to adverse and/or uncertain general economic conditions, especially in the United States and industries where such membership is concentrated.

Health Care Benefits Reinsurance

The Company currently has several reinsurance agreements with non-affiliated insurers that relate to Health Care Benefits insurance policies. The Company entered into these contracts to reduce the risk of catastrophic losses which in turn reduces capital and surplus requirements. The Company frequently evaluates reinsurance opportunities and refines its reinsurance and risk management strategies on a regular basis.

Corporate/Other Segment

The Company presents the remainder of its financial results in the Corporate/Other segment, which consists of:

- Management and administrative expenses to support the overall operations of the Company, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments, expenses associated with the Company's investments in its transformation and Enterprise modernization programs and acquisition-related transaction and integration costs; and
- Products for which the Company no longer solicits or accepts new customers such as large case pensions and long-term care insurance products.

Generic Sourcing Venture

The Company and Cardinal Health, Inc. ("Cardinal") each have a 50% ownership in Red Oak Sourcing, LLC ("Red Oak"), a generic pharmaceutical sourcing entity. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak. Red Oak does not own or hold inventory on behalf of either company.

Working Capital Practices

The Company funds the growth of its businesses through a combination of cash flow from operations, commercial paper and other short-term borrowings, proceeds from sale-leaseback transactions and long-term borrowings. For additional information on the Company's working capital practices, see "Liquidity and Capital Resources" in the MD&A included in Item 7 of this 10-K. The majority of the Retail/LTC segment non-pharmacy revenues are paid in cash, or with debit or credit cards. Managed care organizations, pharmacy benefit managers, government funded health care programs, commercial employers and other third party insurance programs, which represent the vast majority of the Company's consolidated pharmacy revenues, typically settle in less than 30 days. The remainder of the Company's consolidated pharmacy revenues are paid in cash, or with debit or credit cards. Employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-

sponsored plans (with the exception of Medicare Part D services, which are described below), labor groups and expatriates, which represent the vast majority of Health Care Benefits segment revenues, typically settle in less than 30 days. As a provider of Medicare Part D services, the Company contracts annually with CMS. Utilization of services each plan

year results in the accumulation of either a receivable from or a payable to CMS. The timing of settlement of the receivable or payable with CMS takes several quarters, which impacts working capital from year to year.

Colleague Development

As of December 31, 2019, the Company employed approximately 290,000 colleagues in all 50 states, the District of Columbia, Puerto Rico and a number of countries outside the United States. To deliver the highest levels of service to customers, the Company devotes considerable time and attention to its people and service standards. The Company emphasizes attracting and training knowledgeable, friendly and helpful associates to work in the organization.

Intellectual Property

The Company has registered and/or applied to register a variety of trademarks and service marks used throughout its businesses, as well as domain names, and relies on a combination of copyright, patent, trademark and trade secret laws, in addition to contractual restrictions, to establish and protect the Company's proprietary rights. The Company regards its intellectual property as having significant value in the Pharmacy Services, Retail/LTC and Health Care Benefits segments. The Company is not aware of any facts that could materially impact the continuing use of any of its intellectual property.

Government Regulation

Overview

The Company's operations are subject to comprehensive federal, state and local laws and regulations and comparable multiple levels of international regulation in the jurisdictions in which it does business. There also continues to be a heightened level of review and/or audit by federal, state and international regulators of the health and related benefits industry's business and reporting practices. In addition, many of the Company's PBM clients and the Company's payors in the Retail/LTC segment, including insurers, Medicare Part D plans, Managed Medicaid plans and managed care organizations ("MCOs"), are themselves subject to extensive regulations that affect the design and implementation of prescription drug benefit plans that they sponsor. Similarly, the Company's LTC clients, such as skilled nursing facilities, are subject to government regulations, including many of the same government regulations to which the Company is subject.

The laws and rules governing the Company's businesses and interpretations of those laws and rules continue to expand and become more restrictive each year and are subject to frequent change. The application of these complex legal and regulatory requirements to the detailed operation of the Company's businesses creates areas of uncertainty. Further, there are numerous proposed health care, financial services and other laws and regulations at the federal, state and international levels, some of which could adversely affect the Company's businesses if they are enacted. The Company cannot predict whether pending or future federal or state legislation or court proceedings, including fundamental changes to the dynamics of one or more of the industries in which it competes, such as the federal or one or more state governments fundamentally restructuring the Commercial, Medicare or Medicaid marketplace or reducing payments to the Company under or financing for Medicare, Medicaid, dual eligible or special needs programs, increasing its involvement in drug reimbursement, pricing, purchasing, and/or importation or changing the laws governing PBMs, will change various aspects of the industries in which it competes or the health care industry generally or the impact those changes will have on the Company's businesses, operating results, cash flows and/or stock price, but the effects could be materially adverse. Any failure or alleged failure to comply with applicable laws and regulations summarized below, or any adverse applications or interpretations of, or changes in, the laws and regulations affecting the Company and/or its businesses, could have a material adverse effect on the Company's operating results, financial condition, cash flows and/or stock price. See Item 3 of this 10-K, "Legal Proceedings," for further information.

The Company can give no assurance that its businesses, financial condition, operating results and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations, including the laws and regulations described in this Government Regulation section, as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits,

investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

Laws and Regulations Related to Multiple Segments of the Company's Business

Laws Related to Reimbursement by Government Programs - The Company is subject to various federal and state laws concerning its submission of claims and other information to Medicare, Medicaid and other federal and state government-sponsored health care programs. Potential sanctions for violating these laws include recoupment or reduction of government reimbursement amounts, civil penalties, treble damages, and exclusion from participation in government health care programs. Such laws include the federal False Claims Act (the "False Claims Act"), the federal anti-kickback statute, state false claims acts and anti-kickback statutes in most states, the federal "Stark Law" and related state laws. In particular, the False Claims Act prohibits intentionally submitting, conspiring to submit, or causing to be submitted, false claims, records, or statements to the federal government, or intentionally failing to return overpayments, in connection with reimbursement by federal government programs. In addition, any claim for government reimbursement also violates the False Claims Act where it results from a violation of the federal anti-kickback statute.

Both federal and state false claims laws permit private individuals to file *qui tam* or "whistleblower" lawsuits on behalf of the federal or state government. Participants in the health and related benefits industry, including the Company, frequently are subject to actions under the False Claims Act or similar state laws. The federal Stark Law generally prohibits physicians from referring Medicare or Medicaid beneficiaries for certain services, including outpatient prescription drugs, to any entity with which the physician, or an immediate family member of the physician, has a financial relationship. The Stark Law further prohibits the entity receiving a prohibited referral from presenting a claim for reimbursement by Medicare or Medicaid for services furnished pursuant to the prohibited referral. Various states have enacted similar laws.

The ACA - The ACA made broad-based changes to the U.S. health care system. While the Company anticipates continued efforts in 2020 and beyond to invalidate, modify, repeal or replace the ACA, the Company expects aspects of the ACA to continue to significantly impact its business operations and operating results, including pricing, medical benefit ratios ("MBRs") and the geographies in which the Company's products are available.

While most of the significant aspects of the ACA became effective during or prior to 2014, parts of the ACA continue to evolve through the promulgation of executive orders, legislation, regulations and guidance as well as ongoing litigation. Additional changes to the ACA and those regulations and guidance at the federal and/or state level are likely, and those changes are likely to be significant. Growing federal and state budgetary pressures make it more likely that any changes, including changes at the state level in response to changes to, or invalidation, repeal or replacement of, the ACA and/or changes in the funding levels and/or payment mechanisms of federally supported benefit programs, will be adverse to us. For example, if any elements of the ACA are invalidated or repealed at the federal level, the Company expects that some states would seek to enact similar requirements, such as prohibiting pre-existing condition exclusions, prohibiting rescission of insurance coverage, requiring coverage for dependents up to age 26, requiring guaranteed renewability of insurance coverage and prohibiting lifetime limits on insurance coverage.

The expansion of health care coverage contemplated by the ACA is being funded in part by reductions to the reimbursements the Company and other health plans are paid by the federal government for Medicare members, among other sources. While not all-inclusive, the following are some of the key funding changes related to the ACA (assuming it continues to be implemented in its current form) that become effective on or after January 1, 2020. The Company continues to evaluate these provisions and the related regulations and regulatory guidance to determine the impact that they will have on its business operations and operating results:

- The repeal of the annual non-tax deductible industry-wide HIF for calendar years after 2020. The HIF was $14.3 billion for 2018 and suspended for 2019. As currently enacted, the HIF will be $15.5 billion for 2020.
- The repeal of the non-tax deductible 40% excise tax on employer-sponsored health care benefits above a certain threshold that was scheduled to begin in 2022.
- Reduced funding for Medicaid expansion, which began in 2017.

The ACA also specifies minimum medical loss ratios ("MLRs") for Commercial and Medicare Insured products, specifies features required to be included in Commercial benefit designs, limits Commercial individual and small group rating and pricing practices, encourages additional competition (including potential incentives for new participants to enter the marketplace) and significantly increases federal and state oversight of health plans, including

regulations and processes that could delay or limit the Company's ability to appropriately increase its health plan premium rates. This in turn could adversely affect the Company's ability to continue to participate in certain product lines and/or geographies that it serves today.

Potential repeal of the ACA, ongoing legislative, regulatory and administrative policy changes to the ACA, the results of federal and state level elections, pending litigation challenging the constitutionality of the ACA or funding for the law and federal budget negotiations continue to create uncertainty about the ultimate impact of the ACA. The time frame for conclusion and final outcome and ultimate impact of this litigation are uncertain. Given the inherent difficulty of foreseeing the nature and scope of future changes to the ACA and how states, businesses and individuals will respond to those changes, the Company cannot predict the impact on it of future changes to the ACA. It is reasonably possible that invalidation, repeal or replacement of or other changes to the ACA and/or states' responses to such changes, in the aggregate, could have a significant adverse effect on the Company's businesses, operating results and cash flows.

Medicare Regulation - The Company's Medicare Advantage products compete directly with Original Medicare and Medicare Advantage products offered by other Medicare Advantage organizations and Medicare Supplement products offered by other insurers. The Company's Medicare PDP and Medicare Supplement products are products that Medicare beneficiaries who are enrolled in Original Medicare purchase to enhance their Original Medicare coverage.

The Company continues to expand the number of counties in which it offers Medicare products. The Company expects to further expand its Medicare service area and products in 2020 and is seeking to substantially grow its Medicare membership, revenue and operating results over the next several years, including through growth in Medicare Supplement products. The anticipated organic expansion of the Medicare service area and Medicare products offered and the Medicare-related provisions of the ACA significantly increase the Company's exposure to funding and regulation of, and changes in government policy with respect to and/or funding or regulation of, the various Medicare programs in which the Company participates, including changes in the amounts payable to us under those programs and/or new reforms or surcharges on existing programs. For example, the ACA requires minimum MLRs for Medicare Advantage and Medicare Part D plans of 85%. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS.

The Company's Medicare Advantage and PDP products are heavily regulated by CMS. The regulations and contractual requirements applicable to the Company and other private participants in Medicare programs are complex, expensive to comply with and subject to change. For example, in the second quarter of 2014, CMS issued a final rule implementing the ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. The precise interpretation, impact and legality of this rule are not clear and are subject to pending litigation. Payments the Company receives from CMS for its Medicare Advantage and Part D businesses also are subject to risk adjustment based on the health status of the individuals enrolled. Elements of that risk adjustment mechanism continue to be challenged by the DOJ, the Office of the Inspector General of the U.S. Department of Health and Human Services (the "OIG") and CMS itself. Substantial changes in the risk adjustment mechanism, including changes that result from enforcement or audit actions, could materially affect the amount of the Company's Medicare reimbursement, require the Company to raise prices or reduce the benefits offered to Medicare beneficiaries, and potentially limit the Company's (and the industry's) participation in the Medicare program.

The Company has invested significant resources to comply with Medicare standards, and its Medicare compliance efforts will continue to require significant resources. CMS may seek premium and other refunds, prohibit the Company from continuing to market and/or enroll members in or refuse to passively enroll members in one or more of the Company's Medicare or Medicare-Medicaid demonstration (historically known as "dual eligible") plans, exclude us from participating in one or more Medicare, dual eligible or dual eligible special needs plan programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS regulations or its Medicare contractual requirements. The Company's Medicare Supplement products are regulated at the state level and subject to similar significant compliance requirements and risks.

CMS regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare Advantage and PDP beneficiaries. For example, CMS conducts risk adjustment data validation ("RADV") audits of a subset of Medicare Advantage contracts for each contract year. Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various years for RADV audit, and the number of RADV audits continues to increase. The OIG also is auditing the Company's risk adjustment data and that of other companies, and the Company expects CMS and the OIG to continue auditing risk adjustment data. The Company also has received Civil Investigative Demands

("CIDs") from, and provided documents and information to, the Civil Division of the DOJ in connection with a current investigation of its patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

On October 26, 2018, CMS issued proposed rules related to, among other things, changes to the RADV audit methodology established by CMS in 2012. CMS projects that the changes to the RADV audit methodology would increase its recoveries from Medicare Advantage plans as a result of RADV audits. CMS has requested comments on the proposed rules, including whether the proposed RADV rule change should apply retroactively to audits of Medicare Advantage plans for contract year 2011 and forward. The Company is evaluating the potential adverse effect, which could be material, on the Company's operating results, financial condition, and cash flows if the proposed RADV rule change were adopted as proposed. CMS also has announced that its goal is to subject all Medicare Advantage contracts to either a comprehensive or a targeted RADV audit for each contract year.

A portion of each Medicare Advantage plan's reimbursement is tied to the plan's "star ratings." The star rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management, compliance and overall customer satisfaction. Only Medicare Advantage plans with an overall star rating of four or more stars (out of five stars) are eligible for a quality bonus in their basic premium rates. As a result, the Company's Medicare Advantage plans' operating results in 2020 and going forward will be significantly affected by their star ratings. The Company's star ratings and past performance scores are adversely affected by the compliance issues that arise each year in its Medicare operations. CMS released the Company's 2020 star ratings in October 2019. The Company's 2020 star ratings will be used to determine which of its Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2021. Based on the Company's membership at December 31, 2019, 83% of the Company's Medicare Advantage members were in plans with 2020 star ratings of at least 4.0 stars. CMS will release updated stars ratings in October 2020 that will be used to determine which Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2022. CMS also gives PDPs star ratings which affect PDP's enrollment. Medicare Advantage and PDP plans that are rated less than three stars for three consecutive years are subject to contract termination by CMS. CMS continues to revise its star ratings system to make it harder to achieve four stars or more. Despite the Company's success in achieving high 2020 star ratings and other quality measures and the continuation of its improvement efforts, there can be no assurances that it will be successful in maintaining or improving its star ratings in future years. Accordingly, the Company's Medicare Advantage plans may not be eligible for full level quality bonuses, which could adversely affect the benefits such plans can offer, reduce membership and/or reduce profit margins.

Overall, the Company projects the benchmark payment rates in CMS's April 2019 final notice detailing final Medicare Advantage benchmark payment rates for 2020 (the "Final Notice") will increase funding for the Company's Medicare Advantage business, excluding the impact of the HIF, by approximately 2.0% in 2020 compared to 2019. This 2020 rate increase only partially offsets the challenge the Company faces from the impact of the increasing cost of medical care (including prescription medications) and CMS local and national coverage decisions that require the Company to pay for services and supplies that are not factored into the Company's bids. The federal government may seek to impose restrictions on the configuration of pharmacy or other provider networks for Medicare Advantage and/or PDP plans, or otherwise restrict the ability of these plans to alter benefits, negotiate prices or establish other terms to improve affordability or maintain viability of products. The Company currently believes that the payments it has received and will receive in the near term are adequate to justify the Company's continued participation in the Medicare Advantage and PDP programs, although there are economic and political pressures to continue to reduce spending on the program, and this outlook could change.

Going forward, the Company expects CMS, the OIG, the DOJ, other federal agencies and the U.S. Congress to continue to scrutinize closely each component of the Medicare program (including Medicare Advantage, PDP, demonstration projects such as Medicare-Medicaid plans and provider network access and adequacy), modify the terms and requirements of the program and possibly seek to recast or limit private insurers' role. It is not possible to predict the outcome of this Congressional or regulatory activity, any of which could materially and adversely affect the Company.

Anti-Remuneration Laws - Federal law prohibits, among other things, an entity from knowingly and willfully offering, paying, soliciting or receiving, subject to certain exceptions and "safe harbors," any remuneration to induce the referral of individuals or the purchase, lease or order of items or services for which payment may be made under Medicare, Medicaid or certain other federal and state health care programs. A number of states have similar laws, some of which are not limited to services paid for with government funds. Sanctions for violating these federal and state anti-remuneration laws may include imprisonment, criminal and civil fines, and exclusion from participation in Medicare, Medicaid and other federal and state government-sponsored health care programs. Companies involved in public health care programs such as Medicare and/or Medicaid are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The Company has invested significant resources to comply with Medicare and Medicaid program standards. Ongoing

vigorous law enforcement and the highly technical regulatory scheme mean that the Company's compliance efforts in this area will continue to require significant resources.

Antitrust and Unfair Competition - The U.S. Federal Trade Commission ("FTC") investigates and prosecutes practices that are "unfair trade practices" or "unfair methods of competition." Numerous lawsuits have been filed throughout the United States against pharmaceutical manufacturers, retail pharmacies and/or PBMs under various federal and state antitrust and unfair competition laws challenging, among other things: (i) brand name drug pricing and rebate practices of pharmaceutical manufacturers, (ii) the maintenance of retail or specialty pharmacy networks by PBMs, and (iii) various other business practices of PBMs and retail pharmacies. To the extent that the Company appears to have actual or potential market power in a relevant market or CVS Pharmacy, CVS Specialty or MinuteClinic plays a unique or expanded role in a PBM or Health Care Benefits segment product offering, the Company's business arrangements and uses of confidential information may be subject to heightened scrutiny from an anti-competitive perspective and possible challenge by state and/or federal regulators and/or private parties.

Privacy and Confidentiality Requirements - Many of the Company's activities involve the receipt, use and disclosure by the Company of personally identifiable information ("PII") as permitted in accordance with applicable federal and state privacy and data security laws, which require organizations to provide appropriate privacy and security safeguards for such information. In addition to PII, the Company uses and discloses de-identified data for analytical and other purposes when permitted. Additionally, there are industry standards for handling credit card data known as the Payment Card Industry Data Security Standard, which are a set of requirements designed to help ensure that entities that process, store or transmit credit card information maintain a secure environment. Certain states have incorporated these requirements into state laws or enacted other requirements relating to the use and/or disclosure of PII.

The federal Health Insurance Portability and Accountability Act of 1996 and the regulations issued thereunder (collectively, "HIPAA"), as further modified by the American Recovery and Reinvestment Act of 2009 ("ARRA") impose extensive requirements on the way in which health plans, health care providers, health care clearinghouses (known as "covered entities") and their business associates use, disclose and safeguard protected health information ("PHI"). Further, ARRA requires the Company and other covered entities to report any breaches of PHI to impacted individuals and to the U.S. Department of Health and Human Services ("HHS") and to notify the media in any states where 500 or more people are impacted by the unauthorized release or use of or access to PHI. Criminal penalties and civil sanctions may be imposed for failing to comply with HIPAA standards. The Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), enacted as part of ARRA, amended HIPAA to impose additional restrictions on third-party funded communications using PHI and the receipt of remuneration in exchange for PHI. The HITECH Act also extended HIPAA privacy and security requirements and penalties directly to business associates. HHS has begun to audit health plans, providers and other parties to enforce HIPAA compliance, including with respect to data security.

In addition to HIPAA, state health privacy laws apply to the extent they are more protective of individual privacy than is HIPAA, including laws that place stricter controls on the release of information relating to specific diseases or conditions and requirements to notify members of unauthorized release or use of or access to PHI. States also have adopted regulations to implement provisions of the Financial Modernization Act of 1999 (also known as the Gramm-Leach-Bliley Act ("GLBA")) which generally require insurers, including health insurers, to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a non-affiliated third party. Like HIPAA, GLBA sets a "floor" standard, allowing states to adopt more stringent requirements governing privacy protection. Complying with additional state requirements requires us to make additional investments beyond those the Company has made to comply with HIPAA and GLBA.

The Cybersecurity Information Sharing Act of 2015 encourages organizations to share cyber threat indicators with the federal government and, among other things, directs HHS to develop a set of voluntary cybersecurity best practices for organizations in the health care industry. In addition, states have begun to enact more comprehensive privacy laws and regulations addressing consumer rights to data access, deletion, protection or transparency, such as the California Consumer Privacy Act ("CCPA"). States also are starting to issue regulations and proposed regulations specifically related to cybersecurity, such as the regulations issued by the New York Department of Financial Services. Complying with conflicting cybersecurity regulations, which may differ from state to state, requires significant resources. In addition, differing approaches to state privacy and/or cyber-security regulation and varying enforcement philosophies may materially and adversely affect the Company's ability to standardize its products and services across state lines. Widely-reported large scale commercial data breaches in the United States and abroad increase the likelihood that additional data security legislation will be considered by additional states. These legislative and regulatory developments will impact the design and operation of the Company's businesses, its privacy and security strategy and its web-based and mobile assets.

Finally, each Public Exchange is required to adhere to privacy and security standards with respect to PII, and to impose privacy and security standards that are at least as protective of PII as those the Public Exchange has implemented for itself or non-

Public Exchange entities, which include insurers offering plans through the Public Exchange and their designated downstream entities, including PBMs and other business associates. These standards may differ from, and be more stringent than, HIPAA.

Consumer Protection Laws - The federal government has many consumer protection laws, such as the Federal Trade Commission Act, the Federal Postal Service Act, the Consumer Product Safety Act and the FTC's Telemarketing Sales Rule. Most states also have similar consumer protection laws. In addition, the federal government and most states have adopted laws and/or regulations requiring places of public accommodation, health care services and other goods and services to be accessible to people with disabilities. These consumer protection and accessibility laws and regulations have been the basis for investigations, lawsuits and multistate settlements relating to, among other matters, the marketing of loyalty programs, and health care products and services, pricing accuracy, expired front store products, financial incentives provided by drug manufacturers to pharmacies in connection with therapeutic interchange programs, disclosures related to how personal data is used and protected and the accessibility of goods and services to people with disabilities. As a result of the Company's direct-to-consumer activities, including mobile and web-based solutions offered to members and to other consumers, the Company also is subject to federal and state regulations applicable to electronic communications and to other general consumer protection laws and regulations. For example, the CCPA became effective in 2020, and additional federal and state regulation of consumer privacy protection may be proposed or enacted in 2020. The Company expects these new laws and regulations to impact the design of its products and services and the management and operation of its businesses and to increase its compliance costs.

Telemarketing and Other Outbound Contacts - Certain federal and state laws, such as the Telephone Consumer Protection Act, give the FTC, the Federal Communications Commission and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Pharmacy and Professional Licensure and Regulation - The Company is subject to a variety of intersecting federal and state statutes and regulations that govern the wholesale distribution of drugs; operation of retail, specialty, infusion, LTC and mail order pharmacies; licensure of facilities and professionals, including pharmacists, technicians, nurses and other health care professionals; registration of facilities with the U.S. Drug Enforcement Administration (the "DEA") and analogous state agencies that regulate controlled substances; packaging, storing, shipping and tracking of pharmaceuticals; repackaging of drug products; labeling, medication guides and other consumer disclosures; interactions with prescribers and health care professionals; compounding of prescription medications; dispensing of controlled and non-controlled substances; counseling of patients; transfers of prescriptions; advertisement of prescription products and pharmacy services; security; inventory control; recordkeeping; reporting to Boards of Pharmacy, the U.S. Food and Drug Administration (the "FDA"), the U.S. Consumer Product Safety Commission, the DEA and related state agencies; and other elements of pharmacy practice. Pharmacies are highly regulated and have contact with a wide variety of federal, state and local agencies with various powers to investigate, inspect, audit or solicit information, including Boards of Pharmacy and Nursing, the DEA, the FDA, the DOJ, HHS and others. Many of these agencies have broad enforcement powers, conduct audits on a regular basis, can impose substantial fines and penalties, and may revoke the license, registration or program enrollment of a facility or professional.

State Insurance, HMO and Insurance Holding Company Regulation - A number of states regulate affiliated groups of insurers and HMOs such as the Company under holding company statutes. These laws may, among other things, require prior regulatory approval of dividends and material intercompany transfers of assets and transactions between the regulated companies and their affiliates, including their parent holding companies. The Company expects the states in which its insurance and HMO subsidiaries are licensed to continue to expand their regulation of the corporate governance and internal control activities of its insurance companies and HMOs. Changes to state insurance, HMO and/or insurance holding company laws or regulations or changes to the interpretation of those laws or regulations, including due to regulators' increasing concerns regarding insurance company and/or HMO solvency due, among other things, to past and expected payor insolvencies, could negatively affect the Company's businesses in various ways, including through increases in solvency fund assessments, requirements that the Company hold greater levels of capital and/or delays in approving dividends from regulated subsidiaries.

PBM offerings of prescription drug coverage under certain risk arrangements may be subject to laws and regulations in various states. Such laws may require that the party at risk become licensed as an insurer, establish reserves or

otherwise demonstrate financial viability. Laws that may apply in such cases include insurance laws and laws governing MCOs and limited prepaid health service plans.

The states of domicile of the Company's regulated subsidiaries have statutory risk-based capital, or "RBC", requirements for health and other insurance companies and HMOs based on the National Association of Insurance Commissioners' Risk-Based Capital (RBC) for Insurers Model Act (the "RBC Model Act"). These RBC requirements are intended to assess the capital

adequacy of life and health insurers and HMOs, taking into account the risk characteristics of a company's investments and products. The RBC Model Act sets forth the formula for calculating RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual company's business. In general, under these laws, an insurance company or HMO must submit a report of its RBC level to the insurance department or insurance commissioner of its state of domicile for each calendar year. At December 31, 2019, the RBC level of each of the Company's insurance and HMO subsidiaries was above the level that would require regulatory action.

For information regarding restrictions on certain payments of dividends or other distributions by the Company's HMO and insurance company subsidiaries, see Note 12 ''Shareholders' Equity'' included in Item 8 of this 10-K.

The holding company laws for the states of domicile of certain of the Company's subsidiaries also 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 (such as the Company's ultimate parent company, CVS Health) that controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would control the insurance holding company. Control is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person.

Certain states have laws that prohibit submitting a false claim or making a false record or statement in order to secure reimbursement from an insurance company. These state laws vary, and violation of them may lead to the imposition of civil or criminal penalties.

Government Agreements and Mandates - The Company and/or its various affiliates are subject to certain consent decrees, settlement and other agreements, corrective action plans and corporate integrity agreements with various federal, state and local authorities relating to such matters as privacy practices, controlled substances, PDPs, expired products, environmental and safety matters, marketing and advertising practices, PBM, LTC and other pharmacy operations and various other business practices. Certain of these agreements contain ongoing reporting, monitoring and/or other compliance requirements for the Company. Failure to meet the Company's obligations under these agreements could result in civil or criminal remedies, financial penalties, administrative remedies, and/or exclusion from participation in federal health care programs.

Environmental and Safety Regulation - The Company's businesses are subject to various federal, state and local laws, regulations and other requirements pertaining to protection of the environment, public health and employee safety, including, for example, regulations governing the management of hazardous substances, the cleaning up of contaminated sites, and the maintenance of safe working conditions in the Company's stores, distribution centers and other facilities. Governmental agencies at the federal, state and local levels continue to focus on the retail and health care sectors' compliance with such laws and regulations, and have at times pursued enforcement activities. Any failure to comply with these regulations could result in fines or other sanctions by government authorities.

ERISA Regulation - The Employee Retirement Income Security Act of 1974 ("ERISA"), provides for comprehensive federal regulation of certain employee pension and benefit plans, including private employer and union sponsored health plans and certain other plans that contract with us to provide PBM services. In general, the Company assists plan sponsors in the administration of their health benefit plans, including the prescription drug benefit portion of those plans, in accordance with the plan designs adopted by the plan sponsors. In addition, the Company may have fiduciary duties where it has specifically contracted with a plan sponsor to accept limited fiduciary responsibility, such as for the adjudication of initial prescription drug benefit claims and/or the appeals of denied claims under a plan. In addition to its fiduciary provisions, ERISA imposes civil and criminal liability on service providers to health plans and certain other persons if certain forms of illegal remuneration are made or received. These provisions of ERISA are broadly written and their application to specific business practices is often uncertain.

Some of the Company's health and related benefits and large case pensions products and services and related fees also are subject to potential issues raised by judicial interpretations relating to ERISA. Under those interpretations, together with U.S. Department of Labor ("DOL") regulations, the Company may have ERISA fiduciary duties with respect to PBM members and/or certain general account assets held under contracts that are not guaranteed benefit policies. As a result, certain transactions related to those general account assets are subject to conflict of interest and

other restrictions, and the Company must provide certain disclosures to policyholders annually. The Company must comply with these restrictions or face substantial penalties.

In addition, ERISA generally preempts all state and local laws that relate to employee benefit plans, but the extent of the pre-emption continues to be reviewed by courts, including the U.S. Supreme Court.

Other Legislative Initiatives and Regulatory Initiatives - The U.S. federal and state governments, as well as governments in other countries where the Company does business, continue to enact and seriously consider many broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system and the Company's businesses, operating results and/or cash flows. For example:

- Under the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012 significant, automatic across-the-board budget cuts (known as sequestration) began in March 2013, including Medicare spending cuts of not more than 2% of total program costs per year through 2024. Significant uncertainty remains as to whether and how the U.S. Congress will proceed with actions that create additional federal revenue and/or with entitlement reform. The Company cannot predict future federal Medicare or federal or state Medicaid funding levels or the impact that future federal or state budget actions or entitlement program reform, if it occurs, will have on the Company's businesses, operations or operating results, but the effects could be materially adverse, particularly on the Company's Medicare and/or Medicaid revenues, MBRs and operating results.

- The European Union's ("EU's") General Data Protection Regulation ("GDPR") began to apply across the EU during 2018.

- Other significant legislative and/or regulatory measures which are or recently have been under consideration include the following:

    - Elimination of the payment of manufacturer's rebates on prescription drugs to PBMs, PDPs and Managed Medicaid organizations in connection with federally funded health care programs.

    - Imposing requirements and restrictions on the design and/or administration of pharmacy benefit plans offered by the Company's and its clients' health plans and/or its PBM clients and/or the services the Company provides to those clients, including prohibiting "differential" or "spread" pricing in PBM contracts; restricting or eliminating the use of formularies for prescription drugs; restricting the Company's ability to require members to obtain drugs through a home delivery or specialty pharmacy; restricting the Company's ability to place certain specialty or other drugs in the higher cost tiers of its pharmacy formularies; restricting the Company's ability to make changes to drug formularies and/or clinical programs; limiting or eliminating rebates on pharmaceuticals; requiring the use of up front purchase price discounts on pharmaceuticals in lieu of rebates; restricting the Company's ability to configure its health plan and retail pharmacy provider networks; and restricting or eliminating the use of certain drug pricing methodologies.

    - Increased federal or state government regulation of, or involvement in, the pricing and/or purchasing of drugs.

    - Restricting the Company's ability to limit providers' participation in its networks and/or remove providers from its networks by imposing network adequacy requirements or otherwise (including in its Medicare and Commercial Health Care Benefits products).

    - Imposing assessments on (or to be collected by) health plans or health carriers that may or may not be passed through to their customers. These assessments may include assessments for insolvency, the uninsured, uncompensated care, Medicaid funding or defraying health care provider medical malpractice insurance costs.

    - Mandating coverage by the Company's and its clients' health plans for additional conditions and/or specified procedures, drugs or devices (for example, high cost pharmaceuticals, experimental pharmaceuticals and oral chemotherapy regimens).

    - Regulating electronic connectivity.

    - Mandating or regulating the disclosure of provider fee schedules, manufacturer's rebates and other data about the Company's payments to providers and/or payments the Company receives from pharmaceutical manufacturers.

    - Mandating or regulating disclosure of provider outcome and/or efficiency information.

- Prescribing or limiting members' financial responsibility for health care or other covered services they utilize, including restricting "surprise" bills by providers and by specifying procedures for resolving "surprise" bills.

- Prescribing payment levels for health care and other covered services rendered to the Company's members by providers who do not have contracts with the Company.

- Assessing the medical device status of HIT products and/or solutions, mobile consumer wellness tools and clinical decision support tools, which may require compliance with FDA requirements in relation to some of these products, solutions and/or tools.

- Restricting the ability of employers and/or health plans to establish or impose member financial responsibility.

- Amending or supplementing ERISA to impose greater requirements on PBMs or the administration of employer-funded benefit plans or limit the scope of current ERISA pre-emption, which would among other things expose the Company and other health plans to expanded liability for punitive and other extra-contractual damages and additional state regulation.

It is uncertain whether the Company can counter the potential adverse effects of such potential legislation or regulation on its operating results or cash flows, including whether it can recoup, through higher premium rates, expanded membership or other measures, the increased costs of mandated coverage or benefits, assessments, fees, taxes or other increased costs, including the cost of modifying its systems to implement any enacted legislation or regulations.

The Company's businesses also may be affected by other legislation and regulations. The Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Financial Reform Act") creates incentives for whistleblowers to speak directly to the government rather than utilizing internal compliance programs and reduces the burden of proof under the Foreign Corrupt Practices Act of 1977 (the "FCPA"). There also are laws and regulations that set standards for the escheatment of funds to states.

Health savings accounts, health reimbursement arrangements and flexible spending accounts and certain of the tax, fee and subsidy provisions of the ACA also are regulated by the U.S. Department of the Treasury and the Internal Revenue Service.

The Company also may be adversely affected by court and regulatory decisions that expand or revise the interpretations of existing statutes and regulations or impose medical malpractice or bad faith liability. Federal and state courts, including the U.S. Supreme Court, continue to consider cases, and federal and state regulators continue to issue regulations and interpretations, addressing bad faith liability for denial of medical claims, the scope of ERISA's fiduciary duty requirements, the scope of the False Claims Act and the pre-emptive effect of ERISA on state laws.

Contract Audits - The Company is subject to audits of many of its contracts, including its PBM client contracts, its PBM rebate contracts, its PBM network contracts, its contracts relating to Medicare Advantage and/or Medicare Part D, the agreements the Company's pharmacies enter into with other payors, its Medicaid contracts and its customer contracts. Because some of the Company's contracts are with state or federal governments or with entities contracted with state or federal agencies, audits of these contracts are often regulated by the federal or state agencies responsible for administering federal or state benefits programs, including those which operate Medicaid fee for service plans, Managed Medicaid plans, Medicare Part D plans or Medicare Advantage organizations.

Federal Employee Health Benefits Program - The Company's subsidiaries contract with the Office of Personnel Management (the "OPM") to provide managed health care services under the FEHB program in their service areas. These contracts with the OPM and applicable government regulations establish premium rating arrangements for this program. OPM regulations require that community-rated FEHB plans meet a FEHB program-specific minimum MLR by plan code and market. Managing to these rules is complicated by the simultaneous application of the minimum MLR standards and associated premium rebate requirements of the ACA. The Company also has a contractual arrangement with carriers for the FEHB program, such as the BlueCross BlueShield Association, to provide pharmacy services to federal employees, postal workers, annuitants, and their dependents under the Government-wide Service Benefit Plan, as authorized by the FEHB Act and as part of the FEHB program. Additionally, the Company manages certain FEHB plans on a "cost-plus" basis. These arrangements subject the Company to certain aspects of FEHB Act, and other federal regulations, such as the FEHB Acquisition Regulation, that otherwise would not be applicable to the Company. The OPM also is auditing the Company and its other contractors to, among other things, verify that plans meet their applicable FEHB program-specific MLR and the premiums established under the OPM's Insured contracts and costs allocated pursuant to the OPM's cost-based contracts are in compliance with the requirements of the applicable FEHB program. The OPM may seek premium refunds or institute other sanctions against the Company if it fails to comply with the FEHB program requirements.

Clinical Services Regulation - The Company provides clinical services to health plan and PBM plan members for complex and common medical conditions, including arranging for those members to participate in disease management programs. State laws regulate the practice of medicine, the practice of pharmacy, the practice of nursing and certain other clinical activities. Clinicians engaged in a professional practice in connection with the provision of clinical services must satisfy applicable state licensing requirements and must act within their scope of practice.

Third Party Administration and Other State Licensure Laws - Many states have licensure or registration laws governing certain types of administrative organizations, such as PPOs, TPAs and companies that provide utilization review services. Several states also have licensure or registration laws governing the organizations that provide or administer consumer card programs (also known as cash card or discount card programs).

International Regulation - The Company has insurance licenses in several foreign jurisdictions and does business directly or through local affiliations in numerous countries around the world. The Company has taken steps to be able to continue to serve

customers in the European Economic Area following the United Kingdom's exit from the EU ("Brexit"). However, the impact of Brexit on the Company's international business and operating results is uncertain.

The Company's international operations are subject to different, and sometimes more stringent, legal and regulatory requirements, which vary widely by jurisdiction, including anti-corruption laws; economic sanctions laws; various privacy, insurance, tax, tariff and trade laws and regulations; corporate governance, privacy, data protection (including the EU's General Data Protection Regulation which began to apply across the EU during 2018), data mining, data transfer, labor and employment, intellectual property, consumer protection and investment laws and regulations; discriminatory licensing procedures; compulsory cessions of reinsurance; required localization of records and funds; higher premium and income taxes; limitations on dividends and repatriation of capital; and requirements for local participation in an insurer's ownership. In addition, the expansion of the Company's operations into foreign countries increases the Company's exposure to the anti-bribery, anti-corruption and anti-money laundering provisions of U.S. law, including the FCPA, and corresponding foreign laws, including the U.K. Bribery Act 2010 (the "UK Bribery Act").

Anti-Corruption Laws - The FCPA prohibits offering, promising or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. The Company also is subject to applicable anti-corruption laws of the jurisdictions in which it operates. In many countries outside the United States, health care professionals are employed by the government. Therefore, the Company's dealings with them are subject to regulation under the FCPA. Violations of the FCPA and other anti-corruption laws may result in severe criminal and civil sanctions as well as other penalties, and there continues to be a heightened level of FCPA enforcement activity by the U.S. Securities and Exchange Commission (the "SEC") and the DOJ. The UK Bribery Act is an anti-corruption law that is broader in scope than the FCPA and applies to all companies with a nexus to the United Kingdom. Disclosures of FCPA violations may be shared with the UK authorities, thus potentially exposing companies to liability and potential penalties in multiple jurisdictions. The Company has internal control policies and procedures and conducts training and compliance programs for its employees to deter prohibited practices. However, if the Company's employees or agents fail to comply with applicable laws governing its international or other operations, it may face investigations, prosecutions and other legal proceedings and actions which could result in civil penalties, administrative remedies and criminal sanctions.

Anti-Money Laundering Regulations - Certain lines of the Company's businesses are subject to Treasury anti-money laundering regulations. Those lines of business have implemented anti-money laundering policies designed to ensure their compliance with the regulations. The Company also is subject to anti-money laundering laws in non-U.S. jurisdictions where it operates.

Office of Foreign Assets Control - The Company also is subject to regulation by OFAC. OFAC administers and enforces economic and trade sanctions based on U.S. foreign policy and national security goals against targeted foreign countries and regimes, terrorists, international narcotics traffickers, those engaged in activities related to the proliferation of weapons of mass destruction, and other threats to the national security, foreign policy or economy of the United States. In addition, the Company is subject to similar regulations in the non-U.S. jurisdictions in which it operates.

FDA Regulation - The FDA regulates the Company's compounding pharmacy and clinical research operations. The FDA also generally has authority to, among other things, regulate the manufacture, distribution, sale and labeling of medical devices (including hemodialysis devices such as the device the Company is developing and mobile medical devices) and many products sold through retail pharmacies, including prescription drugs, over-the-counter medications, cosmetics, dietary supplements and certain food items. In addition, the FDA regulates the Company's activities as a distributor of store brand products.

Laws and Regulations Related to the Pharmacy Services Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state and local statutes and regulations governing the operation of its Pharmacy Services segment specifically. Among these are the following:

PBM Laws and Regulation - Legislation and/or regulations seeking to regulate PBM activities in a comprehensive manner have been proposed or enacted in a number of states. This legislation could adversely affect the Company's ability to conduct business on commercially reasonable terms in states where the legislation is in effect and the Company's ability to standardize its PBM products and services across state lines. In addition, certain quasi-

regulatory organizations, including the National Association of Boards of Pharmacy and the National Association of Insurance Commissioners ("NAIC") and the National Council of Insurance Legislators, have issued model regulations or may propose future regulations concerning PBMs and/or PBM activities. Similarly, credentialing organizations such as NCQA and URAC may establish voluntary standards regarding

PBM, mail order pharmacy and/or specialty pharmacy activities. While the actions of these quasi-regulatory or standard-setting organizations do not have the force of law, they may influence states to adopt their requirements or recommendations and influence client requirements for PBM, mail order pharmacy and/or specialty pharmacy services. Moreover, any standards established by these organizations could also impact the Company's health plan clients and/or the services provided to those clients and/or the Company's health plans.

The Company's PBM activities also are regulated directly and indirectly at the federal and state levels, including being subject to the False Claims Act and state false claims acts and federal and state anti-kickback laws. These laws and regulations govern, and proposed legislation and regulations may govern and/or further restrict, critical PBM practices, including disclosure, receipt and retention of rebates and other payments received from pharmaceutical manufacturers; use of, administration of and/or changes to drug formularies, maximum allowable cost ("MAC") list pricing, average wholesale prices ("AWPs") and/or clinical programs; the offering to plan sponsors of pricing that includes retail network "differential" or "spread" (i.e., a difference between the drug price charged to the plan sponsor by a PBM and the price paid by the PBM to the dispensing provider); disclosure of data to third parties; drug utilization management practices; the level of duty a PBM owes its customers; configuration of pharmacy networks; the operations of the Company's pharmacies (including audits of its pharmacies); disclosure of negotiated provider reimbursement rates; disclosure of fees associated with administrative service agreements and patient care programs that are attributable to members' drug utilization; and registration or licensing of PBMs. Failure by the Company or one of its PBM services suppliers to comply with these laws or regulations could result in material fines and/or sanctions and could have a material adverse effect on the Company's operating results and/or cash flows.

The Company's PBM service contracts, including those in which the Company assumes certain risks under performance guarantees or similar arrangements, are generally not subject to insurance regulation by the states. However, state departments of insurance are increasing their oversight of PBM activities due to legislation passing in a number of states requiring PBMs to register or obtain a license with the department. Rulemaking is either underway or has already taken place in a number of states with the areas of focus on licensure requirements, pharmacy reimbursement for generics (MAC reimbursement) and pharmacy audits - most of which fall under the state insurance code.

Pharmacy Network Access Legislation - Medicare Part D and a majority of states now have some form of legislation affecting the Company's (and its health plans' and its health plan clients') ability to limit access to a pharmacy provider network or remove pharmacy network providers. For example, certain "any willing provider" legislation may require the Company or its clients to admit a nonparticipating pharmacy if such pharmacy is willing and able to meet the plan's price and other applicable terms and conditions for network participation. These laws could negatively affect the services and economic benefits achievable through a limited pharmacy provider network. Also, a majority of states now have some form of legislation affecting the Company's ability (and the Company's and its client health plans' ability) to conduct audits of network pharmacies regarding claims submitted to the Company for payment. These laws could negatively affect the Company's ability to recover overpayments of claims submitted by network pharmacies that the Company identifies through pharmacy audits.

Pharmacy Pricing Legislation - A number of states have passed legislation regulating the Company's ability to manage and establish MACs for generic prescription drugs. MAC methodology is a common cost management practice used by private and public payors (including CMS) to pay pharmacies for dispensing generic prescription drugs. MAC prices specify the allowable reimbursement by a PBM for a particular strength and dosage of a generic drug that is available from multiple manufacturers but sold at different prices. State legislation can regulate the disclosure of MAC prices and MAC price methodologies, the kinds of drugs that a PBM can pay for at a MAC price, and the rights of pharmacies to appeal a MAC price established by a PBM. These laws could negatively affect the Company's ability to establish MAC prices for generic drugs.

Formulary and Plan Design Regulation - A number of government entities regulate the administration of prescription drug benefits. HHS regulates how Medicare Part D formularies are developed and administered, including requiring the inclusion of all drugs in certain classes and categories, subject to limited exceptions. Under the ACA, CMS imposes drug coverage requirements for health plans required to cover essential health benefits, including plans offered through federal or state Public Exchanges. Additionally, the NAIC and health care accreditation agencies like NCQA and URAC have developed model acts and standards for formulary development that are often incorporated into government requirements. Many states regulate the scope of prescription drug coverage, as well as the delivery channels to receive prescriptions, for insurers, MCOs and Medicaid managed care plans. The increasing government regulation of formularies could significantly affect the Company's ability to develop and administer formularies, pharmacy networks and other plan design features on behalf of its insurer, MCO

and other clients. Similarly, some states prohibit health plan sponsors from implementing certain restrictive pharmacy benefit plan design features. This regulation could limit or preclude (i) limited networks, (ii) a requirement to use particular providers, (iii) copayment differentials among providers and (iv) formulary tiering practices.

Laws and Regulations Related to the Retail/LTC Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state and local statutes and regulations governing the operation of its Retail/LTC segment specifically. Among these are the following:

Retail Medical Clinics - States regulate retail medical clinics operated by nurse practitioners or physician assistants through physician oversight, clinic and lab licensure requirements and the prohibition of the corporate practice of medicine. A number of states have implemented or proposed laws or regulations that impact certain components of retail medical clinic operations such as physician oversight, signage, third party contracting requirements, bathroom facilities, and scope of services. These laws and regulations may affect the operation and expansion of the Company's owned and managed retail medical clinics.

Other Laws - Other federal, state and local laws and regulations also impact the Company's retail operations, including laws and regulations governing the practice of optometry, the practice of audiology, the provision of dietician services and the sale of durable medical equipment, contact lenses, eyeglasses, hearing aids and alcohol.

Laws and Regulations Related to the Health Care Benefits Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state, local and international statutes and regulations governing its Health Care Benefits segment specifically.

Overview - Differing approaches to state insurance regulation and varying enforcement philosophies may materially and adversely affect the Company's ability to standardize its Health Care Benefits products and services across state lines. These laws and regulations, including the ACA, restrict how the Company conducts its business and result in additional burdens and costs to the Company. Significant areas of governmental regulation include premium rates and rating methodologies, underwriting rules and procedures, required benefits, sales and marketing activities, provider rates of payment, restrictions on health plans' ability to limit providers' participation in their networks and/or remove providers from their networks and financial condition (including reserves and minimum capital or risk based capital requirements). These laws and regulations are different in each jurisdiction and vary from product to product.

Each health insurer and HMO must file periodic financial and operating reports with the states in which it does business. In addition, health insurers and HMOs are subject to state examination and periodic license renewal. Applicable laws also restrict the ability of the Company's regulated subsidiaries to pay dividends, and certain dividends require prior regulatory approval. In addition, some of the Company's businesses and related activities may be subject to PPO, managed care organization, utilization review or TPA-related licensure requirements and regulations. These licensure requirements and regulations differ from state to state, but may contain provider network, contracting, product and rate, financial and reporting requirements. There also are laws and regulations that set specific standards for the Company's delivery of services, payment of claims, fraud prevention, protection of consumer health information, and payment for covered benefits and services.

Required Regulatory Approvals - The Company must obtain and maintain regulatory approvals to price, market and administer many of its Health Care Benefits products. Supervisory agencies, including CMS, the Center for Consumer Information and Insurance Oversight and the DOL, as well as state health, insurance, managed care and Medicaid agencies, have broad authority to take one or more of the following actions:

- Grant, suspend and revoke the Company's licenses to transact business;
- Suspend or exclude the Company from participation in government programs;
- Suspend or limit the Company's authority to market products;
- Regulate many aspects of the products and services the Company offers, including the pricing and underwriting of many of its products and services;
- Assess damages, fines and/or penalties;

- Terminate the Company's contract with the government agency and/or withhold payments from the government agency to the Company;
- Impose retroactive adjustments to premiums and require the Company to pay refunds to the government, customers and/or members;
- Restrict the Company's ability to conduct acquisitions or dispositions;

- Require the Company to maintain minimum capital levels in its subsidiaries and monitor its solvency and reserve adequacy;

- Regulate the Company's investment activities on the basis of quality, diversification and other quantitative criteria; and/or

- Exclude the Company's plans from participating in Public Exchanges if they are deemed to have a history of "unreasonable" premium rate increases or fail to meet other criteria set by HHS or the applicable state.

The Company's operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time the Company receives subpoenas and other requests for information from, federal, state and international supervisory and enforcement agencies, attorneys general and other state, federal and international governmental authorities and legislators.

Commercial Product Pricing and Underwriting Restrictions - Pricing and underwriting regulation by states limits the Company's underwriting and rating practices and those of other health insurers, particularly for small employer groups, and varies by state. In general, these limitations apply to certain customer segments and limit the Company's ability to set prices for new or renewing groups, or both, based on specific characteristics of the group or the group's prior claim experience. In some states, these laws and regulations restrict the Company's ability to price for the risk it assumes and/or reflect reasonable costs in the Company's pricing.

The ACA expanded the premium rate review process by, among other things, requiring the Company's Commercial Insured rates to be reviewed for "reasonableness" at either the state or the federal level. HHS established a federal premium rate review process that generally applies to proposed premium rate increases equal to or exceeding a federally (or lower state) specified threshold. HHS's rate review process imposes additional public disclosure requirements as well as additional review on filings requesting premium rate increases equal to or exceeding this "reasonableness" threshold. These combined state and federal review requirements may prevent, further delay or otherwise affect the Company's ability to price for the risk it assumes, which could adversely affect its MBRs and operating results, particularly during periods of increased utilization of medical services and/or medical cost trend or when such utilization and/or trend exceeds the Company's projections.

The ACA also specifies minimum MLRs of 85% for large group Commercial products and 80% for individual and small group Commercial products. Because the ACA minimum MLRs are structured as "floors" for many of their requirements, states have the latitude to enact more stringent rules governing these restrictions. For Commercial products, states have and may adopt higher minimum MLR requirements, use more stringent definitions of "medical loss ratio," incorporate minimum MLR requirements into prospective premium rate filings, require prior approval of premium rates or impose other requirements related to minimum MLR. Minimum MLR requirements and similar actions further limit the level of margin the Company can earn in its Insured Commercial products while leaving the Company exposed to medical costs that are higher than those reflected in its pricing. The Company also may be subject to significant fines, penalties, premium refunds and litigation if it fails to comply with minimum MLR laws and regulations.

In addition, the Company requested significant increases in its premium rates in its Commercial Health Care Benefits business for 2020 (including as a result of the reinstatement of the HIF for 2020 following the temporary suspension of the HIF for 2019) and expects to continue to request increases in those rates for 2021 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and rating limits, and significant assessments, fees and taxes imposed by the federal and state governments, including as a result of the ACA. The Company's rates also must be adequate to reflect adverse selection in its products, particularly in small group Commercial products, which the Company expects to continue and potentially worsen in 2020. These rate increases may be significant and thus heighten the risks of adverse publicity, adverse regulatory action and adverse selection and the likelihood that the Company's requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

Many of the laws and regulations governing the Company's pricing and underwriting practices also limit the differentials in premium rates insurers and other carriers may charge between new and renewal business, and/or between groups based on differing characteristics. They may also require that carriers disclose to customers the basis

on which the carrier establishes new business and renewal premium rates and limit the ability of a carrier to terminate customers' coverage.

Medicaid Regulation - The Company is seeking to substantially grow its Medicaid, dual eligible and dual eligible special needs plan businesses over the next several years. As a result, the Company also is increasing its exposure to changes in government policy with respect to and/or regulation of the various Medicaid, dual eligible and dual eligible special needs plan programs in which the Company participates, including changes in the amounts payable to the Company under those programs.

Since 2017, Managed Medicaid products, including those the Company offers, are subject to a minimum federal MLR of 85%. A Medicaid managed care quality rating system and provider network adequacy requirements also apply to Medicaid products. Because the federal minimum MLR is structured as a "floor," states have the latitude to enact more stringent rules governing these restrictions. For Managed Medicaid products, states may adopt higher minimum MLR requirements, use more stringent definitions of "medical loss ratio" or impose other requirements related to minimum MLR. Minimum MLR requirements and similar actions further limit the level of margin the Company can earn in its Insured Medicaid products while leaving the Company exposed to medical costs that are higher than those reflected in its pricing. The Company also may be subject to significant fines, penalties, premium refunds and litigation if it fails to comply with minimum MLR laws and regulations.

The impact of Medicaid expansion under the ACA is uncertain. The future of the ACA is uncertain, and states may opt out of the elements of the ACA requiring expansion of Medicaid coverage without losing their current federal Medicaid funding. To date, a number of states and the District of Columbia have expanded Medicaid coverage to the higher eligibility levels contemplated by the ACA. In addition, the election of new governors and/or state legislatures may impact states' previous decisions regarding Medicaid expansion. Proposals for substantial changes to federal funding of state Medicaid programs are likely to be considered in 2020 and beyond, including the possibility of converting federal Medicaid support to block grants (such as the block grant option outlined by CMS on January 30, 2020) and per capita caps on federal funding. Uncertainty regarding federal funding is causing and will continue to cause states to re-evaluate their Medicaid expansions and consider new assessments, fees and/or taxes on health plans. That re-evaluation and any changes to federal funding of state Medicaid programs may adversely affect Medicaid payment rates, the Company's revenues and its Medicaid membership.

The economic aspects of the Medicaid, dual eligible and dual eligible special needs plan business vary from state to state and are subject to frequent change. Medicaid premiums are paid by each state and differ from state to state. The federal government and certain states also are considering proposals and legislation for Medicaid and dual eligible program reforms or redesigns, including restrictions on the collection of manufacturer's rebates on pharmaceuticals by Medicaid MCOs and their contracted PBMs, further program, population and/or geographic expansions of risk-based managed care, increasing beneficiary cost-sharing or payment levels, and changes to benefits, reimbursement, eligibility criteria, provider network adequacy requirements (including requiring the inclusion of specified high cost providers in the Company's networks) and program structure. In some states, current Medicaid and dual eligible funding and premium revenue may not be adequate for the Company to continue program participation. The Company's Medicaid and dual eligible contracts with states (or sponsors of Medicaid managed care plans) are subject to cancellation by the state (or the sponsors of the managed care plans) after a short notice period without cause (for example, when a state discontinues a managed care program) or in the event of insufficient state funding.

The Company's Medicaid, dual eligible and dual eligible special needs plan products also are heavily regulated by CMS and state Medicaid agencies, which have the right to audit the Company's performance to determine compliance with CMS contracts and regulations. The Company's Medicaid products, dual eligible products and CHIP contracts also are subject to complex federal and state regulations and oversight by state Medicaid agencies regarding the services provided to Medicaid enrollees, payment for those services, network requirements (including mandatory inclusion of specified high-cost providers), and other aspects of these programs, and by external review organizations which audit Medicaid plans on behalf of state Medicaid agencies. The laws, regulations and contractual requirements applicable to the Company and other participants in Medicaid and dual eligible programs, including requirements that the Company submit encounter data to the applicable state agency, are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and its Medicaid and dual eligible program compliance efforts will continue to require significant resources. CMS and/or state Medicaid agencies may fine the Company, withhold payments to the Company, seek premium and other refunds, terminate the Company's existing contracts, elect not to award the Company new contracts or not to renew the Company's existing contracts, prohibit the Company from continuing to market and/or enroll members in or refuse to automatically assign members to one or more of the Company's Medicaid or dual eligible products, exclude the Company from participating in one or more Medicaid or dual eligible programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS or state regulations or contractual requirements.

The Company cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid program, nor can it predict the impact those changes will have on its business operations or operating results, but the effects could be materially adverse.

State Workers' Compensation Laws - The Company's workers' compensation business includes the comparison of medical claims data against the applicable state's fee schedule pricing, including applicable regulations and clinical guidelines. State fee schedules, which typically represent the maximum reimbursement for medical services provided to the injured worker, differ by state and change as state laws and regulations are passed and/or amended. The Company's workers' compensation business also includes PBM and care management services, both of which are regulated at the state level. The Company's workers'

compensation customers include insurance carriers and TPAs who also are regulated at the state level. The laws and regulations applicable to the Company and other participants in the workers' compensation business are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and its workers' compensation compliance efforts will continue to require significant resources. The Company may be subject to significant fines, penalties and litigation if it fails to comply with those laws and regulations.

Federal and State Reporting - The Company is subject to extensive financial and business reporting requirements, including penalties for inaccuracies and/or omissions, at both the federal and state level. The Company's ability to comply with certain of these requirements depends on receipt of information from third parties that may not be readily available or reliably provided in all instances. The Company is and will continue to be required to modify its information systems, dedicate significant resources and incur significant expenses to comply with these requirements. However, the Company cannot eliminate the risks of unavailability of or errors in its reports.

Product Design and Administration and Sales Practices - State and/or federal regulatory scrutiny of health care benefit product design and administration and marketing and advertising practices, including the filing of insurance policy forms, the adequacy of provider networks, the accuracy of provider directories, and the adequacy of disclosure regarding products and their administration, is increasing as are the penalties being imposed for inappropriate practices. Medicare, Medicaid and dual eligible products and products offering more limited benefits in particular continue to attract increased regulatory scrutiny.

Guaranty Fund Assessments/Solvency Protection - Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer governed health plans established under the ACA. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that limit future offsets.

Available Information

CVS Health Corporation was incorporated in Delaware in 1996. The corporate office is located at One CVS Drive, Woonsocket, Rhode Island 02895, telephone (401) 765-1500. CVS Health's common stock is listed on the New York Stock Exchange under the trading symbol "CVS." General information about CVS Health is available through the Company's website at *http://www.cvshealth.com*. The Company's financial press releases and filings with the SEC are available free of charge within the Investors section of the Company's website at *http://investors.cvshealth.com*. In addition, the SEC maintains an internet site that contains reports, proxy and information statements and other information regarding issuers, such as the Company, that file electronically with the SEC. The address of that website is *http://www.sec.gov.* The information on or linked to the Company's website is neither a part of nor incorporated by reference in this 10-K or any of the Company's other SEC filings.

In accordance with guidance provided by the SEC regarding use by a company of its websites and social media channels as a means to disclose material information to investors and to comply with its disclosure obligations under SEC Regulation FD, CVS Health Corporation (the "Registrant") hereby notifies investors, the media and other interested parties that it intends to continue to use its media and investor relations website (http://investors.cvshealth.com/) and its Twitter feed (@CVSHealthIR) to publish important information about the Registrant, including information that may be deemed material to investors. The list of social media channels that the Registrant uses may be updated on its media and investor relations website from time to time. The Registrant encourages investors, the media, and other interested parties to review the information the Registrant posts on its website and social media channels as described above, in addition to information announced by the Registrant through its SEC filings, press releases and public conference calls and webcasts.

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Item 1A. Risk Factors.

You should carefully consider each of the following risks and uncertainties and all of the other information set forth in this Form 10-K. These risks and uncertainties and other factors may affect forward-looking statements, including those we make in this Form 10-K or elsewhere, such as in news releases or investor or analyst calls, meetings or presentations, on our websites or through our social media channels. The risks and uncertainties described below are not the only ones we face. There can be no assurance that we have identified all the risks that affect us. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial also may adversely affect our businesses. Any of these risks or uncertainties could cause our actual results to differ materially from our expectations and the expected results discussed in our forward-looking statements. You should not consider past results to be an indication of future performance.

If any of the following risks or uncertainties develops into actual events or if the circumstances described in the risks or uncertainties occur or continue to occur, those events or circumstances could have a material adverse effect on our businesses, operating results, cash flows, financial condition and/or stock price, among other effects on us. You should read the following section in conjunction with the MD&A, included in Item 7 of this Form 10-K, our consolidated financial statements and the related notes, included in Item 8 of this 10-K, and our "Cautionary Statement Concerning Forward-Looking Statements" in this 10-K.

Risks Relating to Our Businesses

Each of our segments operates in a highly competitive and evolving business environment; and gross margins in the industries in which we compete may decline.

Each of our segments, Pharmacy Services, which includes our pharmacy benefit management ("PBM") business, Retail/LTC, and Health Care Benefits, operates in a highly competitive and evolving business environment. Specifically:

- As competition increases in the geographies in which we operate, including competition from new entrants, a significant increase in price compression and/or reimbursement pressures could occur, and this could require us to reevaluate our pricing structures to remain competitive.

- The competitive success of our Pharmacy Services segment is dependent on our ability to establish and maintain contractual relationships with network pharmacies as PBM clients evaluate adopting narrow or restricted retail pharmacy networks.

- The competitive success of our Retail/LTC segment and our specialty pharmacy operations is dependent on our ability to establish and maintain contractual relationships with PBMs and other payors on acceptable terms as the payors' clients evaluate adopting narrow or restricted retail pharmacy networks.

- In our PBM business, we maintain contractual relationships with brand name drug manufacturers that provide for purchase discounts and/or rebates on drugs dispensed by pharmacies in our retail network and by our specialty and mail order pharmacies (all or a portion of which may be passed on to clients). Manufacturer's rebates often depend on a PBM's ability to meet contractual requirements, including the placement of a manufacturer's products on the PBM's formularies. If we lose our relationship with one or more drug manufacturers, or if the discounts or rebates provided by drug manufacturers decline, our operating results, cash flows and/or prospects could be adversely affected.

- The PBM industry has been experiencing price compression as a result of competitive pressures and increased client demands for lower prices, increased revenue sharing, including sharing in a larger portion of rebates received from drug manufacturers, enhanced service offerings and/or higher service levels. Marketplace dynamics and regulatory changes also have adversely affected our ability to offer plan sponsors pricing that includes the use of retail "differential" or "spread," which could adversely affect our future profitability, and we expect these trends to continue.

- Our retail pharmacy, specialty pharmacy and LTC pharmacy operations have been affected by reimbursement pressure caused by competition, including client demands for lower prices, generic drug pricing, earlier than expected generic drug introductions and network reimbursement pressure. If we are unable to increase our prices to reflect, or otherwise mitigate the impact of, increasing costs, our profitability will be adversely

affected. If we are unable to limit our price increases, we may lose customers to competitors with more favorable pricing, adversely affecting our revenues and operating results.

- A shift in the mix of our pharmacy prescription volume towards programs offering lower reimbursement rates as a result of competition or otherwise could adversely affect our margins, including the ongoing shift in pharmacy mix towards 90-day prescriptions at retail and the ongoing shift in pharmacy mix towards Medicare Part D prescriptions.

- PBM client contracts often are for a period of approximately three years. However, PBM clients may require early or periodic re-negotiation of pricing prior to contract expiration. PBM clients are generally well informed, can move between us and our competitors and often seek competing bids prior to expiration of their contracts. We are therefore under pressure

to contain price increases despite being faced with increasing drug costs and increasing operating costs. If we are unable to increase our prices to reflect, or otherwise mitigate the impact of, increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose customers to competitors with more favorable pricing, adversely affecting our revenues and operating results.

- The operating results and margins of our LTC business are further affected by the increased efforts of health care payors to negotiate reduced or capitated pricing arrangements and by the financial health of, and purchases and sales of, our LTC customers.

- In our Health Care Benefits segment we are seeking to substantially grow our Medicaid, dual eligible and dual eligible special needs plan membership over the next several years. In many instances, to acquire and retain our government customers' business, we must bid against our competitors in a highly competitive environment. Winning bids often are challenged successfully by unsuccessful bidders.

- Customer contracts in our Health Care Benefits segment are generally for a period of one year, and our customers have considerable flexibility in moving between us and our competitors. One of the key factors on which we compete for customers, especially in uncertain economic environments, is overall cost. We are therefore under pressure to contain premium price increases despite being faced with increasing health care and other benefit costs and increasing operating costs. If we are unable to increase our prices to reflect, or otherwise mitigate the impact of, increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose members to competitors with more favorable pricing, adversely affecting our revenues and operating results. In response to rising prices, our customers may elect to self-insure or to reduce benefits in order to limit increases in their benefit costs. Alternatively, our customers may purchase different types of products from us that are less profitable. Such elections may result in reduced membership in our more profitable Insured products and/or lower premiums for our Insured products, which may adversely affect our revenues and operating results, although such elections also may reduce our health care and other benefit costs. In addition, our Medicare, Medicaid and CHIP products are subject to termination without cause, periodic re-bid, rate adjustment and program redesign, as customers seek to contain their benefit costs, particularly in an uncertain economy, and our exposure to this risk is increasing as we grow our Government products membership. These actions may adversely affect our membership, revenues and operating results.

- We requested significant increases in our premium rates in our Commercial Health Care Benefits business for 2020 (including as a result of the reinstatement for 2020 of the Health Insurer Fee (the "HIF") imposed by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA") following the temporary suspension of the HIF for 2019) and expect to continue to request increases in those rates for 2021 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and rating limits, and significant assessments, fees and taxes imposed by the federal and state governments, including as a result of the ACA. Our rates also must be adequate to reflect the risk that our products will be selected by people with a higher risk profile or utilization rate than the pool of participants we anticipated when we established pricing for the applicable products (also known as "adverse selection"), particularly in small group Commercial products, which we expect to continue and potentially worsen in 2020. These rate increases may be significant and thus heighten the risks of adverse publicity, adverse regulatory action and adverse selection and the likelihood that our requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

In addition, competitors in each of our businesses may offer services and pricing terms that we may not be willing or able to offer. Competition also may come from new entrants and other sources in the future. Unless we can demonstrate enhanced value to our clients through innovative product and service offerings in the rapidly changing health care industry, we may be unable to remain competitive.

Disruptive innovation by existing or new competitors could alter the competitive landscape in the future and require us to accurately identify and assess such alterations and make timely and effective changes to our strategies and business model to compete effectively. For example, decisions to buy our Pharmacy Services and Health Care Benefits products and services increasingly are made or influenced by consumers, either through direct purchasing (for example, Medicare Advantage plans and PDPs) or through public health insurance exchanges ("Public Exchanges") and private health insurance exchanges (together with Public Exchanges, collectively, "Insurance Exchanges") that allow individual choice. Consumers also are increasingly seeking to access consumer goods and health care products and services locally and through other direct channels such as mobile devices and websites. To compete effectively in the consumer-driven marketplace, we will be required to develop or acquire new capabilities,

attract new talent and develop new service and distribution relationships that respond to consumer needs and preferences.

Changes in marketplace dynamics or the actions of competitors or manufacturers, including industry consolidation, the emergence of new competitors and strategic alliances, and decisions to exclude us from new narrow or restricted retail pharmacy networks could materially and adversely affect our businesses, operating results, cash flows and/or prospects.

A change in our Health Care Benefits product mix may adversely affect our profit margins.

Our Insured Health Care Benefits products that involve greater potential risk generally tend to be more profitable than our ASC products. Historically, smaller employer groups have been more likely to purchase Insured Health Care Benefits products because such purchasers are generally unable or unwilling to bear greater liability for health care expenditures, although over the last several years even relatively small employers have moved to ASC products. We also serve, and expect to grow our business with, government-sponsored programs, including Medicare and Medicaid, that are subject to competitive bids and have lower profit margins than our Commercial Insured Health Care Benefits products. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on the Health Care Benefits segment's operating results.

Negative public perception of the industries in which we operate, or of our industries' or our practices, can adversely affect our businesses, operating results, cash flows and prospects.

Our brand and reputation are two of our most important assets, and the industries in which we operate have been and are negatively perceived by the public from time to time. Negative publicity may come as a result of adverse media coverage, litigation against us and other industry participants, the ongoing public debates over drug pricing, PBMs, government involvement in drug pricing and purchasing, the future of the ACA, "surprise" medical bills, governmental hearings and/or investigations, actual or perceived shortfalls regarding our industries' or our own products and/or business practices (including PBM operations, drug pricing and insurance coverage determinations) and social media and other media relations activities. Negative publicity also may come from a failure to meet customer expectations for consistent, high quality and accessible care. This risk may increase as we continue to offer products and services that make greater use of data and as our business model becomes more focused on delivering health care to consumers.

Negative public perception and/or publicity of our industries in general, or of us or our key vendors, brokers or product distribution networks in particular, can further increase our costs of doing business and adversely affect our operating results and our stock price by:

- adversely affecting our brand and reputation;
- adversely affecting our ability to market and sell our products and/or services and/or retain our existing customers and members;
- requiring us to change our products and/or services;
- reducing or restricting the revenue we can receive for our products and/or services; and/or
- increasing or significantly changing the regulatory and legislative requirements with which we must comply.

We must maintain and improve our relationships with our retail and specialty pharmacy customers and increase the demand for our products and services, including proprietary brands.

The success of our businesses depends in part on customer loyalty, superior customer service and our ability to persuade customers to frequent our retail stores and online sites and to purchase products in additional categories and our proprietary brands. Failure to timely identify or effectively respond to changing consumer preferences and spending patterns, and evolving demographic mixes in the communities we serve, an inability to expand the products being purchased by our clients and customers, or the failure or inability to obtain or offer particular categories of products could adversely affect our relationship with our customers and clients and the demand for our products and services and could result in excess inventories of products.

We offer our retail customers proprietary brand products that are available exclusively at our retail stores and through our online retail sites. The sale of proprietary products subjects us to unique risks including potential product liability risks, mandatory or voluntary product recalls, potential supply chain and distribution chain disruptions for raw

materials and finished products, our ability to successfully protect our intellectual property rights and the rights of applicable third parties, and other risks generally encountered by entities that source, market and sell private-label products. We also face similar risks for the other products we sell in our retail operations, including supply chain and distribution chain disruption risk. Any failure to adequately address some or all of these risks could have an adverse effect on our retail business, operating results, cash flows and/or financial condition. Additionally, an increase in the sales of our proprietary brands may adversely affect our sales of products owned by

our suppliers and adversely impact certain of our supplier relationships. Our ability to locate qualified, economically stable suppliers who satisfy our requirements, and to acquire sufficient products in a timely and effective manner, is critical to ensuring, among other things, that customer confidence is not diminished. Any failure to develop sourcing relationships with a broad and deep supplier base could adversely affect our operating results and erode customer loyalty.

We also could be adversely affected if we fail to identify or effectively respond to changes in marketplace dynamics. For example, specialty pharmacy represents a significant and growing proportion of prescription drug spending in the U.S., a significant portion of which is dispensed outside of traditional retail pharmacies. Because our specialty pharmacy business focuses on complex and high-cost medications, many of which are made available by manufacturers to a limited number of pharmacies (so-called limited distribution drugs) that serve a relatively limited universe of patients, the future growth of our specialty pharmacy business depends largely upon expanding our access to key drugs and penetration in certain treatment categories. Any contraction of our base of patients or reduction in demand for the prescriptions we currently dispense could have an adverse effect on our specialty pharmacy business, operating results and cash flows.

We face risks relating to the availability, pricing and safety profiles of prescription drugs that we purchase and sell.

The profitability of our Retail/LTC and Pharmacy Services segments is dependent upon the utilization of prescription drug products. We dispense significant volumes of brand name and generic drugs from our retail, LTC, specialty and mail order pharmacies, and the retail pharmacies in our PBM's network also dispense significant volumes of brand name and generic drugs. Our revenues, operating results and cash flows may decline if physicians cease writing prescriptions for drugs or the utilization of drugs is reduced due to:

- increased safety risk profiles or regulatory restrictions;
- manufacturing or other supply issues;
- certain products being withdrawn by their manufacturers or transitioned to over-the-counter products;
- future FDA rulings restricting the supply or increasing the cost of products;
- the introduction of new and successful prescription drugs or lower-priced generic alternatives to existing brand name products; or
- inflation in the price of brand name drugs.

In addition, increased utilization of generic drugs (which normally yield a higher gross profit rate than equivalent brand name drugs) has resulted in pressure to decrease reimbursement payments to retail, mail order, specialty and LTC pharmacies for generic drugs, causing a reduction in our margins on sales of generic drugs. Consolidation within the generic drug manufacturing industry and other external factors may enhance the ability of manufacturers to sustain or increase pricing of generic drugs and diminish our ability to negotiate reduced generic drug acquisition costs. Any inability to offset increased brand name or generic prescription drug acquisition costs or to modify our activities to lessen the financial impact of such increased costs could have a significant adverse effect on our operating results.

A number of factors, many of which are beyond our control, contribute to rising health care and other benefit costs. We may not be able to accurately forecast health care and other benefit costs, which could adversely affect our Health Care Benefits segment's operating results.

Premiums for our Insured Health Care Benefits products, which comprised 91% of our Health Care Benefits revenues for 2019, are priced in advance based on our forecasts of health care and other benefit costs during a fixed premium period, which is generally one year. These forecasts are typically developed several months before the fixed premium period begins, are influenced by historical data (and recent historical data in particular), are dependent on our ability to anticipate and detect medical cost trends and changes in our members' behavior and health care utilization patterns and require a significant degree of judgment. For example, our revenue on Medicare policies is based on bids submitted in June of the year before the contract year. Cost increases in excess of our projections cannot be recovered in the fixed premium period through higher premiums. As a result, our profits are particularly

sensitive to the accuracy of our forecasts and our ability to anticipate and detect medical cost trends. Even relatively small differences between predicted and actual health care and other benefit costs as a percentage of premium revenues can result in significant adverse changes in our operating results.

A number of factors contribute to rising health care and other benefit costs, including previously uninsured members entering the health care system, changes in members' behavior and health care utilization patterns, turnover in our membership, additional government mandated benefits or other regulatory changes, changes in the health status of our members, the aging of the population and other changing demographic characteristics, advances in medical technology, increases in the number and

cost of prescription drugs (including specialty pharmacy drugs and ultra-high cost drugs and therapies), direct-to-consumer marketing by drug manufacturers, the increasing influence of social media on our members' health care utilization and other behaviors, changes in health care practices and general economic conditions (such as inflation and employment levels). In addition, government-imposed limitations on Medicare and Medicaid reimbursements to health plans and providers have caused the private sector to bear a greater share of increasing health care and other benefits costs over time, and future amendments or repeal or replacement of the ACA that increase the uninsured population may exacerbate this problem. Other factors that affect our health care and other benefit costs include changes as a result of the ACA, changes to the ACA and other changes in the regulatory environment, the evolution toward a consumer driven business model, new technologies, influenza related health care costs (which may be substantial and higher than we project), clusters of high-cost cases, epidemics or pandemics, health care provider and member fraud, and numerous other factors that are or may be beyond our control. For example, the 2019-2020 influenza season had an earlier than average start and has a higher incidence of influenza than the 2018-2019 influenza season; and influenza related health care costs were higher than Aetna projected in 2017-2018.

Our Health Care Benefits segment's operating results and competitiveness depend in large part on our ability to appropriately manage future health care and other benefit costs through underwriting criteria, product design, provider network configuration, negotiation of favorable provider contracts and medical management programs. Our medical cost management programs may not be successful and may have a smaller impact on health care and benefit costs than we expect. The factors described above may adversely affect our ability to predict and manage health care and other benefit costs, which can adversely affect our competitiveness and operating results.

The reserves we hold for expected claims in our Insured Health Care Benefits products are based on estimates that involve an extensive degree of judgment and are inherently variable. Any reserve, including a premium deficiency reserve, may be insufficient. If actual claims exceed our estimates, our operating results could be materially adversely affected, and our ability to take timely corrective actions to limit future costs may be limited.

A large portion of health care claims are not submitted to us until after the end of the quarter in which services are rendered by providers to our members. Our reported health care costs payable for any particular period reflect our estimates of the ultimate cost of such claims as well as claims that have been reported to us but not yet paid. We also must estimate the amount of rebates payable under the ACA's, the U.S. Centers for Medicare & Medicaid Services' ("CMS's") and the federal Office of Personnel Management's ("OPM's") minimum medical loss ratio ("MLR") rules and the amounts payable by us to, and receivable by us from, the United States federal government under the ACA's remaining premium stabilization program.

Our estimates of health care costs payable are based on a number of factors, including those derived from historical claim experience, but this estimation process also makes use of extensive judgment. Considerable variability is inherent in such estimates, and the accuracy of the estimates is highly sensitive to changes in medical claims submission and processing patterns and/or procedures, turnover and other changes in membership, changes in product mix, changes in the utilization of medical and/or other covered services, including prescription drugs, changes in medical cost trends, changes in our medical management practices and the introduction of new benefits and products. We estimate health care costs payable periodically, and any resulting adjustments, including premium deficiency reserves, are reflected in current-period operating results within benefit costs. For example, as of December 31, 2019 and 2018, we established a premium deficiency reserve of $4 million and $16 million, respectively, related to Medicaid products in the Health Care Benefits segment. A worsening (or improvement) of health care cost trend rates or changes in claim payment patterns from those that we assumed in estimating health care costs payable as of December 31, 2019 would cause these estimates to change in the near term, and such a change could be material.

Furthermore, if we are not able to accurately and promptly anticipate and detect medical cost trends or accurately estimate the cost of incurred but not yet reported claims or reported claims that have not been paid, our ability to take timely corrective actions to limit future health care costs and reflect our current benefit cost experience in our pricing process may be limited, which would further exacerbate the extent of any adverse impact on our operating results. These risks are particularly acute during and following periods when utilization of medical and/or other covered services and/or medical cost trends are below recent historical levels and in products where there is significant turnover in our membership each year, and such risks are further magnified by the ACA and other legislation and regulations that limit our ability to price for our projected and/or experienced increases in utilization and/or medical cost trends.

Our operating results are affected by the health of the economy in general and in the geographies we serve.

Our businesses are affected by the U.S. economy and consumer confidence in general and in the geographies we serve, including various economic factors, including inflation and changes in consumer purchasing power, preferences and/or spending patterns. An unfavorable, uncertain or volatile economic environment could cause a decline in drug utilization, an

increase in health care utilization and dampen demand for PBM services as well as consumer demand for products sold in our retail stores.

If our customers' operating and financial performance deteriorates, or they are unable to make scheduled payments or obtain adequate financing, our customers may not be able to pay timely, or may delay payment of, amounts owed to us. Any inability of our customers to pay us for our products and services may adversely affect our businesses, operating results and cash flows. In addition, both state and federal government sponsored payers, as a result of budget deficits or spending reductions, may suspend payments or seek to reduce their health care expenditures resulting in our customers delaying payments to us or renegotiating their contracts with us.

Further, economic conditions including interest rate fluctuations, changes in capital market conditions and regulatory changes may affect our ability to obtain necessary financing on acceptable terms, our ability to secure suitable store locations under acceptable terms, our ability to execute sale-leaseback transactions under acceptable terms and the value of our investment portfolio. Adverse changes in the U.S. economy, consumer confidence and economic conditions could have an adverse effect on our businesses and financial results. This adverse effect could be further exacerbated by the increasing prevalence of high deductible health plans and health plan designs favoring co-insurance over co-payments as members and other consumers may decide to postpone, or not to seek, medical treatment which may lead them to incur more expensive medical treatment in the future and/or decrease our prescription volumes.

In addition, our Health Care Benefits membership remains concentrated in certain U.S. geographies and in certain industries. Unfavorable changes in health care or other benefit costs or reimbursement rates or increased competition in those geographic areas where our membership is concentrated could therefore have a disproportionately adverse effect on our Health Care Benefits segment's operating results. Our Health Care Benefits membership has been and may continue to be affected by workforce reductions by our customers due to adverse and/or uncertain general economic conditions, especially in the U.S. geographies and industries where our membership is concentrated. As a result, we may not be able to profitably grow and diversify our Health Care Benefits membership geographically, by product type or by customer industry, and our revenues and operating results may be disproportionately affected by adverse changes affecting our customers.

We are exposed to risks relating to the solvency of other insurers.

We are subject to assessments under guaranty fund laws existing in all states for obligations of insolvent insurance companies (including long-term care insurers), HMOs, ACA co-ops and other payors to policyholders and claimants. For example, in the first quarter of 2017, Aetna recorded a discounted estimated liability expense of $231 million pretax for our estimated share of future assessments for long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries. Guaranty funds are maintained by state insurance commissioners to protect policyholders and claimants in the event that an insurer, HMO, ACA co-op and/or other payor becomes insolvent or is unable to meet its financial obligations. These funds are usually financed by assessments against insurers regulated by a state. Future assessments may have an adverse effect on our operating results and cash flows.

Extreme events, or the threat of extreme events, could materially increase our health care (including behavioral health) costs.

Nuclear, biological or other attacks, whether as a result of war or terrorism, other man-made disasters, natural disasters, epidemics, pandemics and other extreme events can affect the U.S. economy in general, our industries and us specifically. In particular, such extreme events or the threat of such extreme events could result in significant health care (including behavioral health) costs, which also would be affected by the government's actions and the responsiveness of public health agencies and other insurers. Such extreme events or the threat of such extreme events also could disrupt our supply chains and/or our distribution chains for the products we sell. In addition, our employees and those of our vendors are concentrated in certain large, metropolitan areas which may be particularly exposed to these events. Such events could adversely affect our businesses, operating results and cash flows, and, in the event of extreme circumstances, our financial condition or viability, particularly if our responses to such events are less adequate than those of our competitors.

Risks From Changes in Public Policy and Other Legal and Regulatory Risks

We are subject to potential changes in public policy, laws and regulations, including reform of the U.S. health care system, which can adversely affect our businesses. Entitlement program reform, if it occurs, could have a material adverse effect on our businesses, operations and/or operating results.

The political environment in which we operate remains uncertain. It is reasonably possible that our business operations and operating results could be materially adversely affected by legislative, regulatory and public policy changes at the federal or state level, increased government involvement in drug reimbursement, pricing, purchasing and/or importation and/or increased regulation of PBMs, including: changes to the Medicare or Medicaid programs (including the block grant option outlined by CMS on January 30, 2020) or the regulatory environment for health care and related benefits, including the ACA; changes to laws or regulations governing drug reimbursement and/or pricing; changes to the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs; changes to laws and/or regulations governing drug manufacturers' rebates; changes to laws and/or regulations governing reimbursements paid to pharmacists by and/or reporting required by PBMs; changes to immigration policies and/or other public policy initiatives. It is not possible to predict whether or when any such changes will occur or what form any such changes may take (including through the use of U.S. Presidential Executive Orders). Other significant changes to health care and related benefits system legislation or regulation as well as changes with respect to tax and trade policies, tariffs and other government regulations affecting trade between the United States and other countries also are possible and could adversely affect our businesses. If we fail to respond adequately to such changes, including by implementing strategic and operational initiatives, or do not respond as effectively as our competitors, our businesses, operations and operating results may be materially adversely affected.

In addition to efforts to amend, repeal or replace the ACA and related regulations, we expect the federal and state governments to continue to enact and seriously consider many broad-based legislative and regulatory proposals that will or could materially impact various aspects of the health care and related benefits system and our businesses. Potential modification to the ACA, including changes in enforcement and/or funding that further destabilize the Public Exchanges, as well as significant changes to Medicaid funding (including the block grant option outlined by CMS on January 30, 2020) could impact the number of Americans with health insurance and, consequently, prescription drug coverage. Further changes to federal health care and related benefits laws, including the ACA, drug reimbursement and pricing laws, laws governing PBMs and/or laws governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, are probable. We cannot predict the effect, if any, that new health care and related benefits legislation, future changes to the ACA or the implementation of or failure to implement the outstanding provisions of ACA, may have on our Pharmacy Services, retail pharmacy, LTC pharmacy and/or Health Care Benefits operations and/or operating results. The federal and many state governments also are considering changes in the interpretation, enforcement and/or application of existing programs, laws and regulations, including changes to payments under and funding of Medicare and Medicaid programs and increased regulation of PBMs.

Further, changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to additional regulation of PBMs (including formulary management or other PBM services), drug pricing or purchasing, patent term extensions and/or purchase discount and/or rebate arrangements with drug manufacturers also could reduce the discounts or rebates we receive. Changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to claims processing and billing, including our ability to use MAC lists and collect transmission fees, also could adversely affect our profitability.

We cannot predict the enactment or content of new legislation or regulations or changes to existing laws or regulations or their enforcement, interpretation or application, or the effect they will have on our business operations or operating results, which could be materially adverse. Even if we could predict such matters, it is not possible to eliminate the adverse impact of public policy changes that would fundamentally change the dynamics of one or more of the industries in which we compete. Examples of such changes include: the federal or one or more state governments fundamentally restructuring or reducing the funding available for Medicare, Medicaid, dual eligible or dual eligible special needs plan programs, increasing its involvement in drug reimbursement, pricing, purchasing and/or importation, changing the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, changing the tax treatment of health or related benefits, or repealing or otherwise significantly altering the ACA. The likelihood of adverse changes remains high due to state and federal budgetary pressures, and our businesses and operating results could be materially and adversely affected by such changes, even if we correctly predict their occurrence.

For more information on these matters, see “Government Regulation” included in Item 1 of this Form 10-K.

If we fail to comply with applicable laws and regulations, many of which are highly complex, we could be subject to significant adverse regulatory actions or suffer brand and reputational harm.

Our businesses are subject to extensive regulation and oversight by state, federal and international governmental authorities. The laws and regulations governing our operations and interpretations of those laws and regulations are increasing in number and complexity, change frequently and can be inconsistent or conflict with one another. In general, these laws and regulations are designed to benefit and protect customers, members and providers rather than us or our investors. In addition, the governmental authorities that regulate our businesses have broad latitude to make, interpret and enforce the laws and regulations that govern us and continue to interpret and enforce those laws and regulations more strictly and more aggressively each year. We also must follow various restrictions on certain of our businesses and the payment of dividends by certain of our subsidiaries put in place by certain state regulators.

Certain of our Pharmacy Services and Retail/LTC operations, products and services are subject to:

- the clinical quality, patient safety and other risks inherent in the dispensing, packaging and distribution of drugs and other health care products and services, including claims related to purported dispensing and other operational errors (any failure by our Pharmacy Services and/or Retail/LTC operations to adhere to the laws and regulations applicable to the dispensing of drugs could subject us to civil and criminal penalties);

- federal and state anti-kickback and other laws that govern our relationship with drug manufacturers, customers and consumers;

- compliance requirements under the Employee Retirement Income Security Act of 1974 ("ERISA"), including fiduciary obligations in connection with the development and implementation of items such as drug formularies and preferred drug listings; and

- federal and state legislative proposals and/or regulatory activity that could adversely affect pharmacy benefit industry practices.

Our Health Care Benefits products are highly regulated, particularly those that serve Medicare, Medicaid, dual eligible, dual eligible special needs and small group Commercial customers and members. The laws and regulations governing participation in Medicare Advantage, Medicare Part D, Medicaid, dual eligible and dual eligible special needs plan programs are complex, are subject to interpretation and can expose us to penalties for non-compliance.

The scope of the practices and activities that are prohibited by federal and state false claims acts is the subject of pending litigation. Claims under federal and state false claims acts can be brought by the government or by private individuals on behalf of the government through a *qui tam* or "whistleblower" suit, and we are a defendant in a number of such proceedings. If we are convicted of fraud or other criminal conduct in the performance of a government program or if there is an adverse decision against us under the federal False Claims Act (the "False Claims Act"), we may be temporarily or permanently suspended from participating in government health care programs, including Medicare Advantage, Medicare Part D, Medicaid, dual eligible and dual eligible special needs plan programs, and we also may be required to pay significant fines and/or other monetary penalties. Whistleblower suits have resulted in significant settlements between governmental agencies and health care companies. The significant incentives and protections provided to whistleblowers under applicable law increase the risk of whistleblower suits.

If we fail to comply with laws and regulations that apply to government programs, we could be subject to criminal fines, civil penalties, premium refunds, prohibitions on marketing or active or passive enrollment of members, corrective actions, termination of our contracts or other sanctions which could have a material adverse effect on our ability to participate in Medicare Advantage, Medicare Part D, Medicaid, dual eligible, dual eligible special needs plan and other programs and on our operating results, cash flows and financial condition.

Our businesses, profitability and growth also may be adversely affected by (i) judicial and regulatory decisions that change and/or expand the interpretations of existing statutes and regulations, impose medical or bad faith liability, increase our responsibilities under ERISA or the remedies available under ERISA, or reduce the scope of ERISA pre-emption of state law claims (including *Rutledge v. Pharm. Care Mgmt. Assoc.*, which is currently pending before the U.S. Supreme Court) or (ii) other legislation and regulations.

If our compliance or other systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions and/or litigation.

In addition to being subject to extensive and complex regulations, many of our contracts with customers include detailed requirements. In order to be eligible to offer certain products or bid on certain contracts, we must demonstrate that we have robust systems and processes in place that are designed to maintain compliance with all applicable legal, regulatory and contractual requirements. These systems and processes frequently are reviewed and audited by our customers and regulators. If our systems and processes designed to maintain compliance with applicable legal and contractual requirements, and to prevent and detect instances of, or the potential for, non-compliance fail or are deemed inadequate, we may suffer brand and reputational harm and be subject to regulatory actions, litigation and other proceedings which may result in damages, fines, suspension or loss of licensure, suspension or exclusion from participation in government programs and/or other penalties, any of which could adversely affect our businesses, operating results, cash flows and/or financial condition.

We routinely are subject to litigation and other adverse legal proceedings, including class actions and qui tam actions. Many of these proceedings seek substantial damages which may not be covered by insurance. These proceedings are costly to defend, may result in changes in our business practices, harm our brand and reputation and adversely affect our businesses and operating results.

PBM, retail pharmacy, mail order pharmacy, specialty pharmacy, LTC pharmacy and health care and related benefits are highly regulated industries whose participants frequently are subject to litigation and other adverse legal proceedings. We are currently subject to various litigation and arbitration matters, investigations, regulatory audits, inspections, government inquiries, and regulatory and other legal proceedings, both inside and outside the U.S. Outside the U.S., contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the U.S. Litigation related to our provision of professional services in our medical clinics, pharmacies and LTC operations is increasing as we expand our services along the continuum of health care.

Litigation, and particularly securities, derivative, collective or class action and *qui tam* litigation, is often expensive and disruptive. Many of the legal proceedings against us seek substantial damages (including non-economic or punitive damages and treble damages), and certain of these proceedings also seek changes in our business practices. While we currently have insurance coverage for some potential liabilities, other potential liabilities may not be covered by insurance, insurers may dispute coverage and/or the amount of our insurance may not be enough to cover the damages awarded or costs incurred. In addition, some types of damages, like punitive damages, may not be covered by insurance, and in some jurisdictions the coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability also may become unavailable or prohibitively expensive in the future.

The outcome of litigation and other adverse legal proceedings is always uncertain, and outcomes that are not justifiable by the evidence or existing law or regulation can and do occur, and the costs incurred frequently are substantial regardless of the outcome. Litigation and other adverse legal proceedings could materially adversely affect our businesses, operating results and/or cash flows because of brand and reputational harm to us caused by such proceedings, the cost of defending such proceedings, the cost of settlement or judgments against us, or the changes in our operations that could result from such proceedings. See Item 3 of this Form 10-K for additional information.

We frequently are subject to regular and special governmental audits, investigations and reviews that could result in changes to our business practices and also could result in material refunds, fines, penalties, civil liabilities, criminal liabilities and other sanctions.

As one of the largest national retail, mail order, specialty and LTC pharmacy, PBM and health care and related benefits providers, we frequently are subject to regular and special governmental market conduct and other audits, investigations and reviews by, and we receive subpoenas and other requests for information from, various federal and state agencies, regulatory authorities, attorneys general, committees, subcommittees and members of the U.S. Congress and other state, federal and international governmental authorities. For example, we have received civil investigative demands ("CIDs") from, and provided documents and information to, the Civil Division of the DOJ in connection with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. CMS and the Office of the Inspector General of the U.S. Department of Health and Human Services (the "OIG") also are auditing the risk adjustment-related data of certain of our Medicare Advantage plans, and the number of such audits continues to increase. Several such audits,

investigations and reviews by governmental authorities currently are pending, some of which may be resolved in 2020, the results of which may be adverse to us.

Federal and state governments have made investigating and prosecuting health care and other insurance fraud, waste and abuse a priority. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical and/or other covered services, improper marketing and violations of patient privacy rights. The regulations and contractual requirements applicable to us and other industry participants are complex and subject to change, making it necessary for us to invest significant resources in complying with our regulatory and contractual requirements. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources. In addition, our medical costs and the medical expenses of our Health Care Benefits ASC customers may be adversely affected if we do not prevent or detect fraudulent activity by providers and/or members.

Regular and special governmental audits, investigations and reviews by federal, state and international regulators could result in changes to our business practices, and also could result in significant or material premium refunds, fines, penalties, civil liabilities, criminal liabilities or other sanctions, including suspension or exclusion from participation in government programs and suspension or loss of licensure. Any of these audits, investigations or reviews could have a material adverse effect on our businesses, operating results, cash flows and/or financial condition or result in significant liabilities and negative publicity for us.

See "Legal and Regulatory Proceedings" in Note 16 "Commitments and Contingencies" included in Item 8 of this 10-K for additional information.

Our litigation and regulatory risk profile are changing as we offer new products and services and expand in business areas beyond our historical core businesses of Pharmacy Services, Retail/LTC and Health Care Benefits.

Historically, we focused primarily on providing Pharmacy Services, Retail/LTC and Health Care Benefits products and services. As a result of our transformation program and other innovation initiatives, we are expanding our presence in the health care space and plan to offer new products and services (such as the home hemodialysis device we are developing) which present a different litigation and regulatory risk profile than the products and services that we historically have offered.

The increased volume of business in areas beyond our historical core businesses and new products and services subject us to litigation and regulatory risks that are different from the risks of providing Pharmacy Services, Retail/LTC and Health Care Benefits products and services and increase significantly our exposure to other risks.

We face unique regulatory and other challenges in our Medicare and Medicaid businesses.

We are seeking to substantially grow the Medicare and Medicaid membership in our Health Care Benefits segment in 2020 and over the next several years. We face unique regulatory and other challenges that may inhibit the growth and profitability of those businesses.

- In April 2019, CMS issued a final notice detailing final Medicare Advantage benchmark payment rates for 2020 (the "Final Notice"). Overall, we project the benchmark rates in the Final Notice will increase funding for our Medicare Advantage business, excluding the impact of the HIF, by approximately 2.0 percent in 2020 compared to 2019. This 2020 rate increase only partially offsets the challenge we face from the impact of the increasing cost of medical care (including prescription medications) and CMS local and national coverage decisions that require us to pay for services and supplies that are not factored into our bids and creates continued pressure on our Medicare Advantage operating results. We cannot predict future Medicare funding levels, the impact of future federal budget actions or ensure that such changes or actions will not have an adverse effect on our Medicare operating results.

- The organic expansion of our Medicare Advantage and Medicare Part D service area is subject to the ability of CMS to process our requests for service area expansions and our ability to build cost competitive provider networks in the expanded service areas that meet applicable network adequacy requirements. CMS' decisions on our requests for service area expansions also may be affected adversely by compliance issues that arise each year in our Medicare operations.

- CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of the services we provide to our Medicare members. As a result of these audits, we may be subject to significant or material retroactive adjustments to and/or withholding of certain premiums and fees, fines, criminal liability, civil monetary penalties, CMS imposed sanctions (including

suspension or exclusion from participation in government programs) or other restrictions on our Medicare, Medicaid and other businesses, including suspension or loss of licensure.

- "Star ratings" from CMS for our Medicare Advantage plans will continue to have a significant effect on our plans' operating results. Since 2015, only Medicare Advantage plans with a star rating of four or higher (out of five) are eligible for a quality bonus in their basic premium rates. CMS continues to change its rating system to make achieving and maintaining a four or higher star rating more difficult. Our star ratings and past performance scores are adversely affected by the compliance issues that arise each year in our Medicare operations. If our star ratings fall below 4 for a significant portion of our Medicare Advantage membership or do not match the performance of our competitors or the star rating quality bonuses are reduced or eliminated, our revenues, operating results and cash flows may be significantly adversely affected.

- Payments we receive from CMS for our Medicare Advantage and Part D businesses also are subject to risk adjustment based on the health status of the individuals we enroll. Elements of that risk adjustment mechanism continue to be challenged by the DOJ, the OIG and CMS itself. Substantial changes in the risk adjustment mechanism, including changes that result from enforcement or audit actions, could materially affect the amount of our Medicare reimbursement, require us to raise prices or reduce the benefits we offer to Medicare beneficiaries, and potentially limit our (and the industry's) participation in the Medicare program.

- Medicare Part D has resulted in increased utilization of prescription medications and puts pressure on our pharmacy gross margin rates due to regulatory and competitive pressures. Further, as a result of the ACA and changes to the retiree drug subsidy rules, clients of our PBM business could decide to discontinue providing prescription drug benefits to their Medicare-eligible members. To the extent this phenomenon occurs, the adverse effects of increasing customer migration into Medicare Part D may outweigh the benefits we realize from growth of our Medicare Part D products.

- Our Medicare Part D operating results and our ability to expand our Medicare Part D business could be adversely affected if: the cost and complexity of Medicare Part D exceed management's expectations or prevent effective program implementation or administration; changes to the regulations regarding how drug costs are reported for Medicare Part D are implemented in a manner that adversely affects the profitability of our Medicare Part D business; changes to the applicable regulations impact our ability to retain fees from third parties including network pharmacies; the government alters Medicare Part D program requirements or reduces funding because of the higher-than-anticipated cost to taxpayers of Medicare Part D or for other reasons; the government mandates the use of point-of-sale manufacturer's rebates or up front drug pricing discounts, makes drug manufacturer's rebates illegal, or makes changes to how pharmacy pay-for-performance is calculated; or reinsurance thresholds are reduced below their current levels.

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

- Federal funding for expanded Medicaid coverage began to decrease in 2017. This reduction is causing states to re-evaluate funding for their Medicaid expansions. That re-evaluation may adversely affect Medicaid payment rates, our Medicaid membership in those states, our revenues, our MLRs and our operating results.

- If we fail to report and correct errors discovered through our own auditing procedures or during a CMS audit or otherwise fail to comply with the applicable laws and regulations, we could be subject to fines, civil monetary penalties or other sanctions, including fines and penalties under the False Claims Act, which could have a material adverse effect on our ability to participate in Medicare Advantage, Part D or other government programs, and on our operating results, cash flows and financial condition.

- In the second quarter of 2014, CMS issued a final rule implementing ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. However, CMS's statements in formalized guidance regarding "overpayments" to Medicare Advantage plans appear to be inconsistent with CMS's prior risk adjustment data validation ("RADV") audit guidance. These statements appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without reconciliation to the principles underlying the fee for service adjustment comparison contemplated by CMS's RADV audit methodology. The precise interpretation, impact and legality of the final rule are not clear and are subject to pending litigation. If Medicare Advantage plans were not paid based on payment model

principles that align with the requirements of the Social Security Act or such payments were not implemented correctly, it could have a material adverse effect on our operating results, cash flows and/or financial condition.

- Certain of our Medicaid contracts require the submission of complete and correct encounter data. The accurate and timely reporting of encounter data is increasingly important to the success of our Medicaid programs because more states are using encounter data to determine compliance with performance standards and, in part, to set premium rates. We have expended and may continue to expend additional effort and incur significant additional costs to collect accurate, or to

correct inaccurate or incomplete, encounter data and have been and could be exposed to premium withholding, operating sanctions and financial fines and penalties for noncompliance. We have experienced challenges in obtaining complete and accurate encounter data due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could affect the Medicaid premium rates we receive and how Medicaid membership is assigned to us, which could have a material adverse effect on our Medicaid operating results and cash flows and/or our ability to bid for, and continue to participate in, certain Medicaid programs.

- Our businesses that dispense drugs also face challenges in the Medicaid space. The ACA made several significant changes to Medicaid rebates and to reimbursement rates. One of these changes was to revise the definition of the Average Manufacturer Price, a pricing element common to most payment formulas, and the reimbursement formula for generic drugs. This change has adversely affected the reimbursements we receive when we dispense prescription drugs to Medicaid recipients.

Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues, and we expect that percentage to increase.

Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues, and we expect that percentage to increase. As our government funded businesses grow, our exposure to changes in federal and state government policy with respect to and/or regulation of the various government funded programs in which we participate also increases.

Our revenues from government funded programs, including in Health Care Benefits' Medicare, Medicaid, dual eligible and dual eligible special needs plan businesses and from government customers in its Commercial business, are dependent on annual funding by the federal government and/or applicable state or local governments. Federal, state and local governments have the right to cancel or not to renew their contracts with us on short notice without cause or if funds are not available. Funding for these programs is dependent on many factors outside our control, including general economic conditions, continuing government efforts to contain health care costs and budgetary constraints at the federal or applicable state or local level and general political issues and priorities.

The U.S. federal government and our other government customers also may reduce funding for health care or other programs, cancel or decline to renew contracts with us, or make changes that adversely affect the number of persons eligible for certain programs, the services provided to enrollees in such programs, our premiums and our administrative and health care and other benefit costs, any of which could have a material adverse effect on our businesses, operating results and cash flows. When federal funding is delayed, suspended or curtailed, we continue to receive, and we remain liable for and are required to fund, claims from providers for providing services to beneficiaries of federally funded health benefits programs in which we participate. An extended federal government shutdown or a delay by Congress in raising the federal government's debt ceiling also could lead to a delay, reduction, suspension or cancellation of federal government spending and a significant increase in interest rates that could, in turn, have a material adverse effect on the value of our investment portfolio, our ability to access the capital markets and our businesses, operating results, cash flows and liquidity.

Possible changes in industry pricing benchmarks and drug pricing generally can adversely affect our PBM and Retail/LTC businesses.

It is possible that the pharmaceutical industry or regulators may evaluate and/or develop an alternative pricing reference to replace Average Wholesale Price ("AWP") or Wholesale Acquisition Cost ("WAC"), which are the pricing references used for many of our PBM and LTC client contracts, drug purchase agreements, retail network contracts, specialty payor agreements and other contracts with third party payors in connection with the reimbursement of drug payments. In addition, many state Medicaid fee-for-service programs ("FFS Medicaid") have established pharmacy network payments on the basis of Actual Acquisition Cost ("AAC"). The use of an AAC basis in FFS Medicaid could have an impact on reimbursement practices in Health Care Benefits' Commercial and other Government products.

Future changes to the use of AWP, WAC or to other published pricing benchmarks used to establish drug pricing, including changes in the basis for calculating reimbursement by federal and state health care programs and/or other payors, could impact the reimbursement we receive from Medicare and Medicaid programs, the reimbursement we receive from our PBM clients and other payors and/or our ability to negotiate rebates and/or discounts with drug

manufacturers, wholesalers, PBMs and retail pharmacies. A failure or inability to fully offset any increased prices or costs or to modify our operations to mitigate the impact of such increases could have a material adverse effect on our operating results. Additionally, any future changes in drug prices could be significantly different than our projections. We cannot predict the effect of these possible changes on our businesses.

We may not be able to obtain adequate premium rate increases in our Insured Health Care Benefits products, which would have an adverse effect on our revenues, MBRs and operating results and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes.

Premium rates for our Insured Health Care Benefits products generally must be filed with state insurance regulators and are subject to their approval, which creates risk for us in the current political and regulatory environment. The ACA generally requires a review by HHS in conjunction with state regulators of premium rate increases that exceed a federally specified threshold (or lower state-specific thresholds set by states determined by HHS to have adequate processes). Rate reviews can magnify the adverse impact on our operating margins, medical benefit ratios ("MBRs") and operating results of increases in health care and other benefit costs, increased utilization of covered services, and ACA assessments, fees and taxes, by restricting our ability to reflect these increases and/or these assessments, fees and taxes in our pricing. Further, our ability to reflect ACA assessments, fees and taxes in our Medicare, Medicaid and CHIP premium rates is limited.

Since 2013, HHS has issued determinations to health plans that their premium rate increases were "unreasonable," and we continue to experience challenges to appropriate premium rate increases in certain states. Regulators or legislatures in several states have implemented or are considering limits on premium rate increases, either by enforcing existing legal requirements more stringently or proposing different regulatory standards. Regulators or legislatures in several states also have conducted hearings on proposed premium rate increases, which can result, and in some instances have resulted, in substantial delays in implementing proposed rate increases even if they ultimately are approved. Our plans can be excluded from participating in small group Public Exchanges if they are deemed to have a history of "unreasonable" rate increases. Any significant rate increases we may request heighten the risks of adverse publicity, adverse regulatory action and adverse selection and the likelihood that our requested premium rate increases will be denied, reduced or delayed, which could adversely affect our MBRs and lead to operating margin compression.

We anticipate continued regulatory and legislative action to increase regulation of premium rates in our Insured Health Care Benefits products. We may not be able to obtain rates that are actuarially justified or that are sufficient to make our policies profitable in one or more product lines or geographies. If we are unable to obtain adequate premium rates and/or premium rate increases, it could materially and adversely affect our operating margins and MBRs and our ability to earn adequate returns on Insured Health Care Benefits products in one or more states or cause us to withdraw from certain geographies and/or products.

Minimum MLR rebate requirements limit the level of margin we can earn in our Insured Health Care Benefits products while leaving us exposed to higher than expected medical costs. Challenges to our minimum MLR rebate methodology and/or reports could adversely affect our operating results.

The ACA's minimum MLR rebate requirements limit the level of margin we can earn in Health Care Benefits' Commercial Insured and Medicare Insured businesses. CMS minimum MLR rebate regulations limit the level of margin we can earn in our Medicaid Insured business. Certain portions of our Health Care Benefits Medicaid and Federal Employees Health Benefits ("FEHB") program business also are subject to minimum MLR rebate requirements in addition to but separate from those imposed by the ACA. Minimum MLR rebate requirements leave us exposed to medical costs that are higher than those reflected in our pricing. The process supporting the management and determination of the amount of MLR rebates payable is complex and requires judgment, and the minimum MLR reporting requirements are detailed. Federal and state auditors are challenging our Commercial Health Care Benefits business' compliance with the ACA's minimum MLR requirements as well as our FEHB plans' compliance with OPM's FEHB program-specific minimum MLR requirements. Our Medicare and Medicaid contracts also are subject to minimum MLR audits. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS. Additional challenges to our methodology and/or reports relating to minimum MLR and related rebates by federal and state regulators and private litigants are reasonably possible. The outcome of these audits and additional challenges could adversely affect our operating results.

Our operating results may be adversely affected by changes in laws and policies governing employers and by union organizing activity.

The federal and certain state legislatures continue to consider and pass legislation that increases our costs of doing business, including increased minimum wages and requiring employers to provide paid sick leave or paid family

leave. In addition, our employee-related operating costs may be increased by union organizing activity. If we are unable to reflect these increased expenses in our pricing or otherwise modify our operations to mitigate the effects of such increases, our operating results will be adversely affected.

We face international political, legal and compliance, operational, regulatory, economic and other risks that may be more significant than in our domestic operations.

We significantly expanded our international operations as a result of the Aetna Acquisition. As a result of our expanded international operations, we face political, legal, compliance, operational, regulatory, economic and other risks that we do not face or that are more significant than in our domestic operations. These risks vary widely by country and include varying regional and geopolitical business conditions and demands, government intervention and censorship, discriminatory regulation, nationalization or expropriation of assets and pricing constraints. Our international products need to meet country-specific customer and member preferences as well as country-specific legal requirements, including those related to licensing, data privacy, data storage and data protection.

Our international operations increase our exposure to, and require us to devote significant management resources to implement controls and systems to comply with, the privacy and data protection laws of non-U.S. jurisdictions, such as the European Union's ("EU's") General Data Protection Regulation ("GDPR"), and the anti-bribery, anti-corruption and anti-money laundering laws of the United States (including the FCPA) and the United Kingdom (including the UK Bribery Act) and similar laws in other jurisdictions. Implementing our compliance policies, internal controls and other systems upon our expansion into new countries and geographies may require the investment of considerable management time and financial and other resources over several years before any significant revenues or profits are generated. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or employees, restrictions or outright prohibitions on the conduct of our business, and significant brand and reputational harm. We must regularly reassess the size, capability and location of our global infrastructure and make appropriate changes, and must have effective change management processes and internal controls in place to address changes in our businesses and operations. Our success depends, in part, on our ability to anticipate these risks and manage these difficulties, and the failure to do so could have a material adverse effect on our brand, reputation, businesses, operating results and/or financial condition.

Our international operations require us to overcome logistical and other challenges based on differing languages, cultures, legal and regulatory schemes and time zones. Our international operations encounter labor laws, standards and customs that can be difficult and make employee relationships less flexible than in our domestic operations and expensive to modify or terminate. In some countries we are required to, or choose to, operate with local business associates, which requires us to manage our relationships with these third parties and may reduce our operational flexibility and ability to quickly respond to business challenges.

In some countries we may be exposed to currency exchange controls or other restrictions that prevent us from transferring funds internationally or converting local currencies into U.S. dollars or other currencies. Fluctuations in foreign currency exchange rates may adversely affect our revenues, operating results and cash flows from our international operations. Some of our operations are, and are increasingly likely to be, in emerging markets where these risks are heightened. Any measures we may implement to reduce the effect of volatile currencies and other risks on our international operations may not be effective.

Risks Associated with Mergers, Acquisitions, and Divestitures

Risks Relating to Our Acquisition of Aetna

We expect to continue to incur significant non-recurring costs associated with combining the operations of CVS Health and Aetna. We may not achieve the net benefit that we project of such expenditures associated with the elimination of duplicative costs, the realization of other efficiencies that we project related to the integration of our businesses or the realization of the growth opportunities that we project from the Aetna Acquisition in the near term, or at all. In addition, the post-closing integration of the operations of CVS Health and Aetna and related matters may require substantial commitments of management and other resources and management time which could otherwise have been devoted to our ongoing businesses and operations and/or to other opportunities that may have been beneficial to us.

Parties with which we do business may experience uncertainty associated with the Aetna Acquisition and/or the post-closing integration process, including with respect to current or future business relationships with the combined business. Our business relationships (including business relationships of our Health Care Benefits segment) may be subject to disruption as customers, members, manufacturers, providers, vendors and others may attempt to negotiate changes in existing business relationships or consider entering into business relationships with parties other than the combined business.

We may be unable to successfully integrate companies we acquire.

Upon the closing of any acquisition we complete, we will need to successfully integrate the products, services and related assets, as well as internal controls into our business operations. If an acquisition is consummated, the integration of the acquired business, its products, services and related assets into our company also may be complex and time-consuming and, if the integration is not fully successful, we may not achieve the anticipated benefits, operating and cost synergies and/or growth opportunities of an acquisition. Potential difficulties that may be encountered in the integration process include the following:

- Integrating personnel, operations and systems (including internal control environments and compliance policies), while maintaining focus on producing and delivering consistent, high quality products and services;
- Coordinating geographically dispersed organizations;
- Disrupting management's attention from our ongoing business operations;
- Retaining existing customers and attracting new customers; and
- Managing inefficiencies associated with integrating our operations.

An inability to realize the full extent of the anticipated benefits, operating and cost synergies, innovations and operations efficiencies or growth opportunities of an acquisition, as well as any delays or additional expenses encountered in the integration process, could have a material adverse effect on our businesses and operating results. Furthermore, acquisitions, even if successfully integrated, may fail to further our business strategy as anticipated, expose us to increased competition or challenges with respect to our products, services or service areas, and expose us to additional liabilities associated with an acquired business including risks and liabilities associated with litigation involving the acquired business. Any one of these challenges or risks could impair our ability to realize any benefit from our acquisitions after we have expended resources on them.

We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities, which may be unsuccessful, cause us to assume unanticipated liabilities, disrupt our existing businesses, be dilutive or lead us to assume significant debt, among other things.

We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities as part of our growth strategy. In addition to the integration risks noted above, some other risks we face with respect to acquisitions and other inorganic growth strategies include:

- we frequently compete with other firms, some of which may have greater financial and other resources and a greater tolerance for risk, to acquire attractive companies;
- the acquired, alliance and/or joint venture businesses may not perform as projected;
- the goodwill or other intangible assets established as a result of our acquisitions may be incorrectly valued or may become impaired; for example, in 2018 we took $6.1 billion of goodwill impairment charges related to our LTC reporting unit within the Retail/LTC segment;
- we may assume unanticipated liabilities, including those that were not disclosed to us or which we underestimated;
- the acquired businesses, or the pursuit of other inorganic growth strategies, could disrupt or compete with our existing businesses, distract management, result in the loss of key employees, divert resources, result in tax costs or inefficiencies and make it difficult to maintain our current business standards, controls, information technology systems, policies, procedures and performance;
- as we did in the Aetna Acquisition, we may finance future acquisitions and other inorganic growth strategies by issuing common stock for some or all of the purchase price, which would dilute the ownership interests of our stockholders;
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as we did in the Aetna Acquisition, we may incur significant debt in connection with acquisitions (whether to finance acquisitions or by assuming debt from the businesses we acquire);

- we may not have the expertise to manage and profitably grow the businesses we acquire, and we may need to rely on the retention of key personnel and other suppliers of businesses we acquire, which may be difficult or impossible to accomplish;

- we may enter into merger or purchase agreements but, due to reasons within or outside our control, fail to complete the related transactions, which could result in termination fees or other penalties that could be material, cause material disruptions to our businesses and operations and adversely affect our brand and reputation;

- in order to complete a proposed acquisition, we may be required to divest certain portions of our business, for which we may not be able to obtain favorable pricing;

- as is the case with the Aetna Acquisition and our acquisition of Omnicare, Inc., we may be involved in litigation related to mergers or acquisitions, including for matters that occurred prior to the applicable closing, which may be costly to defend and may result in adverse rulings against us that could be material; and

- the integration into our businesses of the businesses and entities we acquire may affect the way in which existing laws and regulations apply to us, including subjecting us to laws and regulations that did not previously apply to us.

In addition, joint ventures present risks that are different from acquisitions, including selection of appropriate joint venture parties, initial and ongoing governance of the joint venture, joint venture compliance activities (including compliance with applicable CMS requirements), growing the joint venture's business in a manner acceptable to all the parties, including other providers in the networks that include joint ventures, maintaining positive relationships among the joint venture parties and the joint venture's customers, and member and business disruption that may occur upon joint venture termination.

Risks Related to Our Operations

Failure to meet customer expectations may harm our brand and reputation, our ability to retain and grow our customer base and membership and our operating results and cash flows.

Our ability to attract and retain customers and members is dependent upon providing cost effective, quality customer service operations (such as call center operations, PBM functions, retail pharmacy and LTC services, retail, mail order and specialty pharmacy prescription delivery, claims processing, customer case installation and online access and tools) that meet or exceed our customers' and members' expectations, either directly or through vendors. As we seek to reduce general and administrative expenses, we must balance the potential impact of cost-saving measures on our customer and other service and performance. If we misjudge the effects of such measures, customer and other service may be adversely affected. We depend on third parties for certain of our customer service, PBM and prescription delivery operations. If we or our vendors fail to provide service that meets our customers' and members' expectations, we may have difficulty retaining or profitably growing our customer base and/or membership, which could adversely affect our operating results. For example, noncompliance with any privacy or security laws or regulations or any security breach involving us or one of our third-party vendors could have a material adverse effect on our businesses, operating results, brand and reputation.

We and our vendors have experienced and continue to experience cyber attacks. We can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future.

We and our vendors have experienced and continue to experience a variety of cyber attacks, and we and our vendors expect to continue to experience cyber attacks going forward. Among other things, we and our vendors have experienced automated attempts to gain access to public facing networks, brute force, SYN flood and distributed denial of service attacks, attempted malware infections, vulnerability scanning, ransomware attacks, spear-phishing campaigns, mass reconnaissance attempts, injection attempts, phishing, PHP injection and cross-site scripting. We also have seen an increase in attacks designed to obtain access to consumers' accounts using illegally obtained demographic information. Although the impact of such attacks has not been material to our operations or operating results through December 31, 2019, we can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future. As we expand our consumer-oriented products and services, increase the amount and types of data we acquire, generate and use, increase the amount of information we make available to members, consumers and providers on mobile devices, expand our use of vendors, expand internationally and expand our use of social media, our exposure to these data security and related cybersecurity risks, including the risk of undetected attacks, damage, loss or unauthorized disclosure or access to and/or disruption of our systems and the customer, member, provider, employee, accountable care organization ("ACO"), joint venture, vendor and other third party information they contain, increases, and the cost of attempting to protect against these risks also increases.

Although we deploy a layered approach to address information security (including cybersecurity) threats and vulnerabilities that is designed to protect confidential information against data security breaches, a compromise of our information security controls or of those businesses with whom we interact, which results in confidential information being accessed, obtained, damaged, or used by unauthorized or improper persons, could harm our reputation and expose us to regulatory actions and claims from customers and clients, financial institutions, payment

card associations and other persons, any of which could adversely affect our businesses, operating results and financial condition. Because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may not immediately produce signs of intrusion, we may be unable to anticipate these techniques or to implement adequate preventative measures. Moreover, a data security breach could require that we expend significant resources related to our information systems and infrastructure, and could

distract management and other key personnel from performing their primary operational duties. We also could be adversely affected by any significant disruption in the systems of third parties we interact with, including key payors and vendors.

The costs of attempting to protect against the foregoing risks and the costs of responding to a cyber-incident are significant. Large scale data breaches at other entities increase the challenge we and our vendors face in maintaining the security of our information technology systems and proprietary information and of our customers', members' and other constituents' sensitive information. Following a cyber-incident, our and/or our vendors' remediation efforts may not be successful, and a cyber-incident could result in interruptions, delays or cessation of service, and loss of existing or potential customers and members. In addition, breaches of our and/or our vendors' security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about us, our customers, our members or other third-parties, could expose our customers', members' and other constituents' private information and our customers, members and other constituents to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, and result in investigations, regulatory enforcement actions, material fines and penalties, loss of customers, litigation or other actions which could have a material adverse effect on our brand, reputation, businesses, operating results and cash flows.

Data governance failures can adversely affect our reputation, businesses and prospects. Our use and disclosure of members', customers' and other constituents' sensitive information is subject to complex regulations at multiple levels. We would be adversely affected if we or our business associates or other vendors fail to adequately protect members', customers' or other constituents' sensitive information.

Our information systems are critical to the operation of our businesses. We collect, process, maintain, retain, evaluate, utilize and distribute large amounts of personal health and financial information and other confidential and sensitive data about our customers, members and other constituents in the ordinary course of our businesses. Some of our information systems rely upon third party systems to accomplish these tasks. The use and disclosure of such information is regulated at the federal, state and international levels, and these laws, rules and regulations are subject to change and increased enforcement activity, such as the California Consumer Privacy Act which went into effect January 1, 2020, the EU's GDPR which began to apply across the EU during 2018 and the audit program implemented by HHS under HIPAA. In some cases, such laws, rules and regulations also apply to our vendors and/or may hold us liable for any violations by our vendors. International laws, rules and regulations governing the use and disclosure of such information are generally more stringent than U.S. laws and regulations, and they vary from jurisdiction to jurisdiction. Noncompliance with any privacy or security laws or regulations, or any security breach, cyber-attack or cybersecurity breach, and any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, sensitive or confidential customer, member or other constituent information, whether by us, by one of our business associates or vendors or by another third party, could require us to expend significant resources to remediate any damage, could interrupt our operations and could adversely affect our brand and reputation, membership and operating results and also could expose and/or has exposed us to mandatory disclosure to the media, litigation (including class action litigation), governmental investigations and enforcement proceedings, material fines, penalties and/or remediation costs, and compensatory, special, punitive and statutory damages, consent orders, adverse actions against our licenses to do business and/or injunctive relief, any of which could adversely affect our businesses, operating results, cash flows or financial condition.

Our businesses depend on our customers', members' and other constituents' willingness to entrust us with their health related and other sensitive personal information. Events that adversely affect that trust, including inadequate disclosure to our members or customers of our uses of their information, failing to keep our information technology systems and our customers', members' and other constituents' sensitive information secure from significant attack, theft, damage, loss or unauthorized disclosure or access, whether as a result of our action or inaction (including human error) or that of our business associates, vendors or other third parties, could adversely affect our brand and reputation, membership and operating results and also could expose and/or has exposed us to mandatory disclosure to the media, litigation (including class action litigation), governmental investigations and enforcement proceedings, material fines, penalties and/or remediation costs, and compensatory, special, punitive and statutory damages, consent orders, adverse actions against our licenses to do business and/or injunctive relief, any of which could adversely affect our businesses, operating results, cash flows or financial condition. Large scale data breaches at other entities increase the challenge we and our vendors face in maintaining the security of our information technology systems and proprietary information and of our customers', members' and other constituents' sensitive information. There can be no assurance that additional such failures will not occur, or if any do occur, that we will detect them or that they can be sufficiently remediated.

Product liability, product recall or personal injury issues could damage our reputation and have a significant adverse effect on our businesses, operating results, cash flows and/or financial condition.

The products that we sell could become subject to contamination, product tampering, mislabeling, recall or other damage. In addition, errors in the dispensing and packaging of drugs and consuming drugs in a manner that is not prescribed could lead to serious injury or death. Product liability or personal injury claims may be asserted against us with respect to any of the drugs or other products we sell or services we provide. For example, we are a defendant in hundreds of litigation proceedings relating to opioids and the sale of products containing talc. Our businesses involve the provision of professional services, including by pharmacists, physician assistants, nurses and nurse practitioners, which exposes us to professional liability claims. Should a product or other liability issue arise, the coverage available under our insurance programs and the indemnification amounts available to us from third parties may not be adequate to protect us against the financial impact of the related claims. We also may not be able to maintain our existing levels of insurance on acceptable terms in the future. A product liability or personal injury issue or judgment against us or a product recall could damage our reputation and have a significant adverse effect on our businesses, operating results and/or financial condition.

We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success, and our failure to do so could adversely affect our businesses, operating results and/or future performance.

Our ability to attract and retain qualified and experienced employees is essential to meet our current and future goals and objectives. There is no guarantee we will be able to attract and retain such employees or that competition among potential employers will not result in increased compensation and/or benefits costs. If we are unable to retain existing employees or attract additional employees, or we experience an unexpected loss of leadership, we could experience a material adverse effect on our businesses, operating results and/or future performance.

In addition, our failure to adequately plan for succession of senior management and other key management roles or the failure of key employees to successfully transition into new roles could have a material adverse effect on our businesses, operating results and/or future performance. The succession plans we have in place and our employment arrangements with certain key executives do not guarantee the services of these executives will continue to be available to us.

Sales of our products and services are dependent on our ability to attract and motivate internal sales personnel and independent third-party brokers, consultants and agents. New distribution channels create new disintermediation risk. We may be subject to penalties or other regulatory actions as a result of the marketing practices of brokers and agents selling our products.

Our products are sold primarily through our sales personnel, who frequently work with independent brokers, consultants and agents who assist in the production and servicing of business. The independent brokers, consultants and agents generally are not dedicated to us exclusively and may frequently recommend and/or market health care benefits products of our competitors. Accordingly, we must compete intensely for their services and allegiance. Our sales could be adversely affected if we are unable to attract, retain or motivate sales personnel and third-party brokers, consultants and agents, or if we do not adequately provide support, training and education to this sales network regarding our complex product portfolio, or if our sales strategy is not appropriately aligned across distribution channels. This risk is heightened as we develop, operate and expand our consumer-oriented products and services and we expand in the health care space and our business model evolves to include a greater focus on consumers and direct-to-consumer sales, such as competing for sales on Insurance Exchanges.

New distribution channels for our products and services continue to emerge, including Private Exchanges operated by health care consultants and technology companies. These channels may make it more difficult for us to directly engage consumers and other customers in the selection and management of their health care benefits, in health care utilization and in the effective navigation of the health care system. We also may be challenged by new technologies and marketplace entrants that could interfere with our existing relationships with customers and health plan members in these areas.

In addition, there have been several investigations regarding the marketing practices of brokers and agents selling health care and other insurance products and the payments they receive. These investigations have resulted in enforcement actions against companies in our industry and brokers and agents marketing and selling those companies' products. For example, CMS and state departments of insurance have increased their scrutiny of the

marketing practices of brokers and agents who market Medicare products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans and/or changes to industry practices, which could adversely affect our ability to market our products.

Failure of our businesses to effectively collaborate could prevent us from maximizing our operating results.

To maximize our overall Enterprise value, our various businesses need to collaborate effectively. Our businesses need to be aligned in order to prioritize goals and coordinate the design of new products intended to utilize the offerings of multiple businesses, including our transformation and Enterprise modernization programs. In addition, misaligned incentives, information siloes, ineffective product development and failure of our corporate governance policies or procedures, for example significant financial decisions being made at an inappropriate level in our organization, also could prevent us from maximizing our operating results and/or achieving our financial and other projections.

The failure or disruption of our information technology systems or the failure of our information technology infrastructure to support our businesses could adversely affect our reputation, businesses, operating results and cash flows.

Our information systems are subject to damage or interruption from power outages, facility damage, computer and telecommunications failures, computer viruses, security breaches (including credit card or personally identifiable information breaches), cyber-attacks, vandalism, catastrophic events and human error. If our information systems are damaged, fail to work properly or otherwise become unavailable, we may incur substantial costs to repair or replace them, and may experience reputational damage, loss of critical information, customer disruption and interruptions or delays in our ability to perform essential functions and implement new and innovative services. In addition, compliance with changes in U.S. and foreign laws and regulations, including privacy and information security laws and standards, may cause us to incur significant expense due to increased investment in technology and the development of new operational processes.

Our business success and operating results depend in part on effective information technology systems and on continuing to develop and implement improvements in technology. Pursuing multiple initiatives simultaneously could make this continued development and implementation significantly more challenging.

Many aspects of our operations are dependent on our information systems and the information collected, processed, stored, and handled by these systems. We rely heavily on our computer systems to manage our ordering, pricing, point-of-sale, pharmacy fulfillment, inventory replenishment, claims processing, customer loyalty and subscription programs, finance and other processes. Throughout our operations, we collect, process, maintain, retain, evaluate, utilize and distribute large amounts of confidential and sensitive data and information, including personally identifiable information and protected health information, that our customers, members and other constituents provide to purchase products or services, enroll in programs or services, register on our websites, interact with our personnel, or otherwise communicate with us. In addition, for these operations, we depend in part on the secure transmission of confidential information over public networks.

We have many different information and other technology systems supporting our businesses (including as a result of our acquisitions). Our businesses depend in large part on these systems to adequately price our products and services; accurately establish reserves, process claims and report operating results; and interact with providers, employer plan sponsors, customers, members, consumers and vendors in an efficient and uninterrupted fashion. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Certain of our technology systems (including software) are older, legacy systems that are less flexible, less efficient and require a significant ongoing commitment of capital and human resources to maintain, protect and enhance them and to integrate them with our other systems. We must re-engineer and reduce the number of these systems to meet changing consumer and vendor preferences and needs, improve our productivity and reduce our operating expenses. We also need to develop or acquire new technology systems, contract with new vendors or modify certain of our existing systems to support the consumer-oriented and transformation products and services we are developing, operating and expanding and/or to meet current and developing industry and regulatory standards, including to keep pace with continuing changes in information processing technology and emerging cybersecurity risks and threats. If we fail to achieve these objectives, our ability to profitably grow our business and/or our operating results may be adversely affected.

In addition, information technology and other technology and process improvement projects, including our transformation and Enterprise modernization programs, frequently are long-term in nature and may take longer to complete and cost more than we expect and may not deliver the benefits we project once they are complete. If we do not effectively and efficiently secure, manage, integrate and enhance our technology portfolio (including vendor sourced systems), we could, among other things, have problems determining health care and other benefit cost

estimates and/or establishing appropriate pricing, meeting the needs of customers, consumers, providers, members and vendors, developing and expanding our consumer-oriented products and services or keeping pace with industry and regulatory standards, and our operating results may be adversely affected.

We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.

We accept payments using a variety of methods, including cash, checks, credit cards, debit cards, gift cards, mobile payments and potentially other technologies in the future. Acceptance of these payment methods subjects us to rules, regulations, contractual obligations and compliance requirements, including payment network rules and operating guidelines, data security standards and certification requirements, and rules governing electronic funds transfers. These requirements may change in the future, which could make compliance more difficult or costly. For certain payment options, including credit and debit cards, we pay interchange and other fees, which could increase periodically thereby raising our operating costs. We rely on third parties to provide payment processing services, including the processing of credit cards, debit cards, and various other forms of electronic payment. If these vendors are unable to provide these services to us, or if their systems are compromised, our operations could be disrupted. The payment methods that we offer also expose us to potential fraud and theft by persons seeking to obtain unauthorized access to, or exploit any weaknesses in, the payment systems we use. If we fail to abide by applicable rules or requirements, or if data relating to our payment systems is compromised due to a breach or misuse, we may be responsible for any costs incurred by payment card issuing banks and other third parties or subject to fines and higher transaction fees. In addition, our reputation and ability to accept certain types of payments could each be harmed resulting in reduced sales and adverse effects on our operating results.

Both our and our vendors' operations are subject to a variety of business continuity hazards and risks, any of which could interrupt our operations or otherwise adversely affect our performance and operating results.

We and our vendors are subject to business continuity hazards and other risks, including natural disasters, utility and other mechanical failures, acts of war or terrorism, disruption of communications, data security and preservation, disruption of supply or distribution, safety regulation and labor difficulties. The occurrence of any of these or other events to us or our vendors might disrupt or shut down our operations or otherwise adversely affect our operations. We also may be subject to certain liability claims in the event of an injury or loss of life, or damage to property, resulting from such events. Although we have developed procedures for crisis management and disaster recovery and business continuity plans and maintain insurance policies that we believe are customary and adequate for our size and industry, our insurance policies include limits and exclusions and, as a result, our coverage may be insufficient to protect against all potential hazards and risks incident to our businesses. In addition, our crisis management and disaster recovery procedures and business continuity plans may not be effective. Should any such hazards or risks occur, or should our insurance coverage be inadequate or unavailable, our businesses, operating results, cash flows and financial condition could be adversely affected.

Financial Risks

We would be adversely affected if we do not effectively deploy our capital. Downgrades or potential downgrades in our credit ratings, should they occur, could adversely affect our brand and reputation, businesses, operating results, cash flows and financial condition.

Our operations generate significant capital, and we have the ability to raise additional capital. The manner in which we deploy our capital, including investments in our businesses, our operations (such as information technology and other strategic and capital projects), dividends, acquisitions, share and/or debt repurchases, repayment of debt, reinsurance or other capital uses, impacts our financial strength, claims paying ability and credit ratings issued by nationally-recognized statistical rating organizations. Credit ratings issued by nationally-recognized statistical rating organizations are broadly distributed and generally used throughout our industries. Our ratings reflect each rating organization's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to our insureds. We believe our credit ratings and the financial strength and claims paying ability of our principal insurance and HMO subsidiaries are important factors in marketing our Health Care Benefits products to certain of our customers.

Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future. In connection with the completion of the Aetna Acquisition, each of Standard & Poor's, Moody's and Fitch downgraded certain of our debt, financial strength and/or other credit ratings. Downgrades in our ratings could adversely affect our businesses, operating results, cash flows and financial condition.

Goodwill and other intangible assets could, in the future, become impaired.

As of December 31, 2019, we had $112.9 billion of goodwill and other intangible assets. During the year ended December 31, 2018, we took $6.1 billion of goodwill impairment charges related to our LTC reporting unit within the Retail/LTC segment.

Goodwill and indefinitely-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable. When evaluating goodwill for potential impairment, we compare the fair value of our reporting units to their respective carrying amounts. We estimate the fair value of our reporting units using a combination of a discounted cash flow method and a market multiple method. If the carrying amount of a reporting unit exceeds its estimated fair value, a goodwill impairment loss is recognized in an amount equal to the excess to the extent of the goodwill balance. Estimated fair values could change if, for example, there are changes in the business climate, industry-wide changes, changes in the competitive environment, adverse legal or regulatory actions or developments, changes in capital structure, cost of debt, interest rates, capital expenditure levels, operating cash flows or market capitalization. Because of the significance of our goodwill and intangible assets, any future impairment of these assets could require material noncash charges to our operating results, which also could have a material adverse effect on our financial condition.

Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative investments and other investments, and our operating results and/or our financial condition.

The global capital markets, including credit markets, continue to experience volatility and uncertainty. As an insurer, we have a substantial investment portfolio that supports our policy liabilities and surplus and is comprised largely of debt securities of issuers located in the U.S. As a result, the income we earn from our investment portfolio is largely driven by the level of interest rates in the U.S., and to a lesser extent the international financial markets; and volatility, uncertainty and/or disruptions in the global capital markets, particularly the U.S. credit markets, and governments' monetary policy, particularly U.S. monetary policy, can significantly and adversely affect the value of our investment portfolio, our operating results and/or our financial condition by:

- significantly reducing the value and/or liquidity of the debt securities we hold in our investment portfolio and creating realized capital losses that reduce our operating results and/or unrealized capital losses that reduce our shareholders' equity;
- keeping interest rates low on high-quality short-term or medium-term debt securities (such as we have experienced during recent years) and thereby materially reducing our net investment income and operating results as the proceeds from securities in our investment portfolio that mature or are otherwise disposed of continue to be reinvested in lower yielding securities;
- reducing the fair values of our investments if interest rates rise;
- causing non-performance of or defaults on their obligations to us by third parties, including customers, issuers of securities in our investment portfolio, mortgage borrowers and/or reinsurance and/or derivatives counterparties;
- making it more difficult to value certain of our investment securities, for example if trading becomes less frequent, which could lead to significant period-to-period changes in our estimates of the fair values of those securities and cause period-to-period volatility in our net income and shareholders' equity;
- reducing our ability to issue short-term debt securities at attractive interest rates, thereby increasing our interest expense and decreasing our operating results; and
- reducing our ability to issue other securities.

Although we seek, within guidelines we deem appropriate, to match the duration of our assets and liabilities and to manage our credit and counterparty exposures, a failure adequately to do so could adversely affect our net income and our financial condition and, in extreme circumstances, our cash flows.

We have incurred and assumed significant indebtedness which has increased our consolidated interest expense and could adversely affect our business flexibility and increase our borrowing costs.

In order to complete the Aetna Acquisition, we incurred acquisition-related debt financing of approximately $45.0 billion and assumed Aetna's existing indebtedness with a fair value of approximately $8.1 billion. Our substantial indebtedness and elevated debt-to-equity ratio have the effect, among other things, of reducing our flexibility to respond to changing business and economic conditions and increasing our interest expense compared to pre-Aetna

Acquisition periods. In addition, the amount of cash required to service our increased indebtedness levels and thus the demands on our cash resources are greater than the amount of cash flows required to service our indebtedness prior to the Aetna Acquisition. We have suspended share repurchases until we reach our desired debt-to-equity ratio. The increased levels of indebtedness also could reduce funds available to engage in investments in product development, capital expenditures, dividend payments and other activities and may create competitive disadvantages for us relative to other companies with lower debt levels.

Risks Related to Our Relationships with Manufacturers, Providers, Suppliers and Vendors

We face risks relating to the market availability, pricing, suppliers and safety profiles of prescription drugs and other products that we purchase and sell.

Our Retail/LTC segment and our mail order and specialty pharmacy operations generate revenues in significant part by dispensing prescription drugs. Our PBM business generates revenues primarily by contracting with clients to provide prescription drugs and related health care services to plan members. As a result, we are dependent on our relationships with prescription drug manufacturers and suppliers. We acquire a substantial amount of our mail order and specialty pharmacies' prescription drug supply from a limited number of suppliers. Certain of our agreements with such suppliers are short-term and cancelable by either party without cause. In addition, these agreements may allow the supplier to distribute through channels other than us. Certain of these agreements also allow pricing and other terms to be adjusted periodically for changing market conditions or required service levels. A termination or modification to any of these relationships could adversely affect our prescription drug supply and have a material adverse effect on our businesses, operating results and financial condition. Moreover, many products distributed by our pharmacies are manufactured with ingredients that are susceptible to supply shortages. In some cases, we depend upon a single source of supply. Any such supply shortages or loss of any such single source of supply could adversely affect our operating results and cash flows.

Much of the branded and generic drug product that we sell in our pharmacies, and much of the other merchandise we sell, is manufactured in whole or in substantial part outside of the United States. In most cases, the products or merchandise are imported by others and sold to us. As a result, significant changes in tax or trade policies, tariffs or trade relations between the United States and other countries, such as the imposition of unilateral tariffs on imported products, could result in significant increases in our costs, restrict our access to suppliers, depress economic activity, and have a material adverse effect on our businesses, operating results and cash flows. In addition, other countries may change their business and trade policies and such changes, as well as any negative sentiments towards the United States in response to increased import tariffs and other changes in U.S. trade regulations, could adversely affect our businesses.

Our suppliers are independent entities subject to their own operational and financial risks that are outside our control. If our current suppliers were to stop selling prescription drugs to us or delay delivery, including as a result of supply shortages, supplier production disruptions, supplier quality issues, closing or bankruptcies of our suppliers, or for other reasons, we may be unable to procure alternatives from other suppliers in a timely and efficient manner and on acceptable terms, or at all.

Our operating results may be adversely affected if we are unable to contract with providers on competitive terms and develop and maintain attractive networks with high quality providers.

We are seeking to enhance our health care provider networks by entering into joint ventures and other collaborative risk-sharing arrangements with health care providers. Providers' willingness to enter these arrangements with us depends upon, among other things, our ability to provide them with up to date quality of care data to support these value-based contracts. These arrangements are designed to give providers incentives to engage in population health management and optimize delivery of health care to our members. These arrangements also may allow us to expand into new geographies, target new customer groups, increase membership and reduce medical costs and, if we provide technology or other services to the relevant health system or provider organization, may contribute to our revenue and earnings from alternative sources. If such arrangements do not result in the lower medical costs that we project or if we fail to attract health care providers to such arrangements, or are less successful at implementing such arrangements than our competitors, our medical costs may not be competitive and may be higher than we project, our attractiveness to customers may be reduced, we may lose or be unable to grow medical membership, and our ability to profitably grow our business and/or our operating results may be adversely affected.

While we believe joint ventures, ACOs and other non-traditional health care provider organizational structures present opportunities for us, the implementation of our joint ventures and other non-traditional structure strategies may not achieve the intended results, which could adversely affect our operating results and cash flows. Among other things, joint ventures require us to maintain collaborative relationships with our counterparties, continue to gain access to provider rates that make the joint ventures economically sustainable and devote significant management time to the operation and management of the joint ventures. We may not be able to achieve these objectives in one or more of our joint ventures, which could adversely affect our operating results and cash flows.

If our service providers fail to meet their contractual obligations to us or to comply with applicable laws or regulations, we may be exposed to brand and reputational harm, litigation and/or regulatory action. This risk is particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs.

We contract with various third parties to perform certain functions and services and provide us with certain information technology systems. Our arrangements with these third parties may expose us to public scrutiny, adversely affect our brand and reputation, expose us to litigation or regulatory action, and otherwise make our operations vulnerable if we fail to adequately oversee, monitor and regulate their performance or if they fail to meet their contractual obligations to us or to comply with applicable laws or regulations. For example, certain of our vendors have been responsible for releases of sensitive information of our members and employees, which has caused us to incur additional expenses and given rise to regulatory actions and litigation against us.

These risks are particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs, where third parties perform PBM, medical management and other member related services for us. Any failure of our or these third parties' prevention, detection or control systems related to regulatory compliance, compliance with our internal policies, data security and/or cybersecurity or any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, members', customers' or other constituents' sensitive information could require us to expend significant resources to remediate any damage, interrupt our operations and adversely affect our brand and reputation and also expose us to whistleblower, class action and other litigation, other proceedings, prohibitions on marketing or active or passive enrollment of members, corrective actions, fines, sanctions and/or penalties, any of which could adversely affect our businesses, operating results, cash flows and/or financial condition.

We may experience increased medical and other benefit costs, litigation risk and customer and member dissatisfaction when providers that do not have contracts with us render services to our Health Care Benefits members.

Some providers that render services to our Health Care Benefits members do not have contracts with us. In those cases, we do not have a pre-established understanding with these providers as to the amount of compensation that is due to them for services rendered to our members. In some states, the amount of compensation due to these nonparticipating providers is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover the difference between what we have paid them and the amount they charged us from our members, which may result in customer and member dissatisfaction. For example, in October 2018, an arbitrator awarded certain claimant hospitals approximately $150 million in a proceeding relating to Aetna's out-of-network benefit payment and administration practices, and in March 2019 that award was reduced to approximately $86 million. Such disputes may cause us to pay higher medical or other benefit costs than we projected.

Continuing consolidation and integration among providers and other suppliers may increase our medical and other covered benefits costs, make it difficult for us to compete in certain geographies and create new competitors.

Hospitals and other providers and health systems continue to consolidate across the health care industry. While this consolidation could increase efficiency and has the potential to improve the delivery of health care services, it also reduces competition and the number of potential contracting parties in certain geographies. These health systems also are increasingly forming and considering forming health plans to directly offer health insurance in competition with us, a process that has been accelerated by the ACA. In addition, ACOs (including Commercial and Medicaid-only ACOs developed as a result of state Medicaid laws), practice management companies, consolidation among and by integrated health systems and other changes in the organizational structures that physicians, hospitals and other health care providers adopt continues to change the way these providers interact with us and the competitive landscape in which we operate. These changes may increase our medical and other covered benefits costs, may affect the way we price our products and services and estimate our medical and other covered benefits costs and may require us to change our operations, including by withdrawing from certain geographies where we do not have a significant presence across our businesses or are unable to collaborate or contract with providers on acceptable terms. Each of these changes may adversely affect our businesses and operating results.

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Item 1B. Unresolved Staff Comments.

There are no unresolved SEC Staff Comments.

Item 2. Properties.

The Company's principal office is an owned building complex located in Woonsocket, Rhode Island, which totals approximately one million square feet. The Company also leases office space in other locations in the United States.

Pharmacy Services Segment

The Pharmacy Services segment includes owned or leased mail service dispensing pharmacies, call centers, on-site pharmacy stores, retail specialty pharmacy stores, specialty mail service pharmacies and branches for infusion and enteral services throughout the United States.

Retail/LTC Segment

As of December 31, 2019, the Retail/LTC segment operated the following properties:

- Approximately 8,170 retail stores, of which approximately 5% were owned. Net selling space for retail stores was approximately 80.3 million square feet as of December 31, 2019. Approximately 45% of the store base was opened or significantly remodeled within the last five years;
- Approximately 1,725 retail pharmacies and approximately 80 clinics in Target stores;
- Owned distribution centers and leased distribution facilities throughout the U.S. totaling approximately 10.5 million square feet; and
- Owned and leased LTC pharmacies throughout the U.S. and an owned LTC repackaging facility.

In connection with certain business dispositions completed between 1995 and 1997, the Company continues to guarantee lease obligations for 79 former stores. The Company is indemnified for these guarantee obligations by the respective initial purchasers. These guarantees generally remain in effect for the initial lease term and any extension thereof pursuant to a renewal option provided for in the lease prior to the time of the disposition. For additional information on these guarantees, see "Lease Guarantees" in Note 16 ''Commitments and Contingencies'' included in Item 8 of this 10-K.

Health Care Benefits Segment

The Health Care Benefits segment's principal office is an owned building complex located in Hartford, Connecticut, which totals approximately 1.7 million square feet. The Health Care Benefits segment also owns or leases office space in other locations in the United States and several other countries.

Management believes that the Company's owned and leased facilities are suitable and adequate to meet the Company's anticipated needs. At the end of the existing lease terms, management believes the leases can be renewed or replaced by alternative space. For additional information on the amount of right-of-use assets and lease liabilities for the Company's leases, see Note 6 ''Leases'' included in Item 8 of this 10-K.

Item 3. Legal Proceedings.

I. Legal Proceedings

The information contained in Note 16 ''Commitments and Contingencies'' included in Item 8 of this 10-K is incorporated herein by reference.

II. Environmental Matters

Item 103 of SEC Regulation S-K requires disclosure of environmental legal proceedings with a governmental authority if management reasonably believes that the proceedings involve potential monetary sanctions of $100,000 or more. The Company is in the process of negotiating with the New York State Department of Environmental Conservation to resolve claims of

alleged historical noncompliance with hazardous waste regulations in connection with LTC pharmacies in the State of New York. These proceedings are not material to the Company's business or financial condition.

Item 4. Mine Safety Disclosures.

Not applicable.

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Information about our Executive Officers

The following sets forth the name, age and biographical information for each of the Registrant's executive officers as of February 18, 2020. In each case the officer's term of office extends to the date of the meeting of the CVS Health Board of Directors (the "Board") following the next annual meeting of stockholders of CVS Health. Previous positions and responsibilities held by each of the executive officers over the past five years or more are indicated below:

Lisa G. Bisaccia, age 63, Executive Vice President of CVS Health Corporation since March 2016 and Chief Human Resources Officer of CVS Health Corporation since January 2010; Senior Vice President of CVS Health Corporation from January 2010 through February 2016. Ms. Bisaccia is also a member of the board of directors of Aramark, a leading global provider of food, facilities and uniform services.

Eva C. Boratto, age 53, Executive Vice President and Chief Financial Officer of CVS Health Corporation since November 2018; Executive Vice President - Controller and Chief Accounting Officer of CVS Health Corporation from March 2017 through November 2018; Senior Vice President - Controller and Chief Accounting Officer of CVS Health Corporation from July 2013 through February 2017.

Troyen A. Brennan, M.D., age 65, Executive Vice President and Chief Medical Officer of CVS Health Corporation since November 2008; Executive Vice President and Chief Medical Officer of Aetna Inc. from February 2006 through November 2008.

James D. Clark, age 55, Senior Vice President - Controller and Chief Accounting Officer of CVS Health Corporation since November 2018; Vice President - Finance and Accounting of CVS Pharmacy, Inc. from September 2009 through October 2018.

Joshua M. Flum, age 50, Executive Vice President, Enterprise Strategy and Digital of CVS Health Corporation since November 2018; Executive Vice President, Corporate Strategy and Business Development of CVS Pharmacy, Inc. from June 2016 through October 2018; Executive Vice President - Pharmacy Services of CVS Pharmacy, Inc. from March 2015 through May 2016; Senior Vice President of Retail Pharmacy of CVS Pharmacy, Inc. from December 2010 through February 2015. Mr. Flum is a member of the board of directors of CreditRiskMonitor.com, Inc., a company that facilitates the analysis of corporate financial risk, mostly in the context of the extension of trade credit from one business to another.

Alan M. Lotvin, M.D., age 58, served as Executive Vice President - Transformation of CVS Health Corporation from June 2018 through February 2020, and will serve as Executive Vice President of CVS Health Corporation and President of CVS Caremark following the departure of Mr. Rice. Dr. Lotvin served as Executive Vice President - Specialty Pharmacy, CVS Caremark from November 2012 through May 2018.

Karen S. Lynch, age 57, Executive Vice President of CVS Health Corporation since November 2018; President of Aetna since January 2015; Executive Vice President, Local and Regional Businesses of Aetna from February 2013 through December 2014. Ms. Lynch is a member of the board of directors of U.S. Bancorp, a banking and financial services company.

Larry J. Merlo, age 64, President and Chief Executive Officer of CVS Health Corporation since March 2011; and a director of CVS Health Corporation since May 2010.

Thomas M. Moriarty, age 56, Executive Vice President and General Counsel of CVS Health Corporation since October 2012; Chief Policy and External Affairs Officer since March 2017; Chief Strategy Officer from March 2014 through February 2017.

Derica W. Rice, age 54, Executive Vice President of CVS Health Corporation and President of CVS Caremark since March 2018; Executive Vice President of Global Services and Chief Financial Officer of Eli Lilly & Company from May 2006 through December 2017. Mr. Rice is a director of The Walt Disney Company since March 2019 and was a director of Target Corporation from September 2007 until January 2018. Mr. Rice will be leaving the Company effective March 1, 2020.

Jonathan C. Roberts, age 64, Executive Vice President and Chief Operating Officer of CVS Health Corporation since March 2017 and Interim President of CVS Pharmacy since January 2020; Executive Vice President of CVS Health Corporation and President of CVS Caremark from September 2012 through February 2017.

PART II

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

On February 3, 2020, the Company announced that Richard J. Swift, Richard M. Bracken and Mark T. Bertolini would not stand for re-election at the Company's upcoming Annual Meeting of Stockholders (the "2020 Annual Meeting"). On February 7, 2020, Mr. Bertolini informed the Company of his decision to resign from the Board, effective immediately. On February 10, 2020, the Board reduced the size of the Board from 16 to 15 members effective immediately and further reduced the size of the Board to 13 members effective at the time of the 2020 Annual Meeting.

Market information

CVS Health's common stock is listed on the New York Stock Exchange under the symbol "CVS."

Dividends

CVS Health has paid cash dividends every quarter since becoming a public company. Future dividends will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by CVS Health's Board of Directors.

See Note 12 ''Shareholders' Equity'' included in Item 8 of this 10-K for information regarding CVS Health's dividends.

Holders of common stock

As of February 12, 2020, there were 26,656 registered holders of the registrant's common stock according to the records maintained by the registrant's transfer agent.

Issuer purchases of equity securities

The following share repurchase programs have been authorized by the Board:

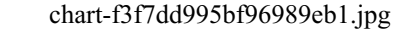
In billions			**Remaining as of**
Authorization Date		**Authorized**	**December 31, 2019**
November 2, 2016 ("2016 Repurchase Program")	$	15.0	$ 13.9
December 15, 2014 ("2014 Repurchase Program")		10.0	—

Each of the share Repurchase Programs was effective immediately. The 2014 Repurchase Program has been completed. The 2016 Repurchase Program permits the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase transactions, and/or other derivative transactions. The 2016 Repurchase Program can be modified or terminated by the Board at any time. During the three months ended December 31, 2019, the Company did not repurchase any shares of common stock.

See Note 12 ''Shareholders' Equity'' included in Item 8 of this 10-K for additional information regarding the Company's share repurchases.

Stock Performance Graph

The following graph compares the cumulative total shareholder return on CVS Health's common stock (assuming reinvestment of dividends) with the cumulative total return on the S&P 500 Index, the S&P 500 Food and Staples Retailing Industry Group Index and the S&P 500 Healthcare Sector Group Index from December 31, 2014 through December 31, 2019. The graph assumes a $100 investment in shares of CVS Health's common stock on December 31, 2014.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	December 31,					
	2014	2015	2016	2017	2018	2019
CVS Health Corporation	$ 100	$ 103	$ 85	$ 80	$ 74	$ 87
S&P 500 (1)	100	101	113	138	132	174
S&P 500 Food & Staples Retail Group Index (2)	100	98	98	111	112	143
S&P 500 Health Care Group Index (1) (3)	100	107	104	127	135	163

(1) Includes CVS Health.

(2) Includes 5 companies (COST, KR, SYY, WBA, WMT).

(3) Includes 61 companies.

The year-ended values of each investment shown in the preceding graph are based on share price appreciation plus dividends, with the dividends reinvested as of the last business day of the month during which such dividends were ex-dividend. The calculations exclude trading commissions and taxes. Total shareholder returns from each investment can be calculated from the year-end investment values shown beneath the graph.

Item 6. Selected Financial Data.

The selected consolidated financial data of CVS Health Corporation as of and for the periods indicated in the five-year period ended December 31, 2019, has been derived from the consolidated financial statements of CVS Health Corporation. The selected consolidated financial data should be read in conjunction with the MD&A included in Item 7 of this 10-K and the audited consolidated financial statements and related notes included in Item 8 of this 10-K.

In millions, except per share amounts	**2019**	**2018** [1]	**2017**	**2016**	**2015**
Statement of operations data:					
Total revenues	$ 256,776	$ 194,579	$ 184,786	$ 177,546	$ 153,311
Operating income	11,987	4,021	9,538	10,386	9,496
Income (loss) from continuing operations	6,631	(596)	6,631	5,320	5,230
Net income (loss) attributable to CVS Health	6,634	(594)	6,622	5,317	5,237
Per common share data:					
Basic earnings (loss) per common share:					
Income (loss) from continuing operations attributable to CVS Health	$ 5.10	$ (0.57)	$ 6.48	$ 4.93	$ 4.65
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ —	$ (0.01)	$ —	$ 0.01
Net income (loss) attributable to CVS Health	$ 5.10	$ (0.57)	$ 6.47	$ 4.93	$ 4.66
Diluted earnings (loss) per common share:					
Income (loss) from continuing operations attributable to CVS Health	$ 5.08	$ (0.57)	$ 6.45	$ 4.91	$ 4.62
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ —	$ (0.01)	$ —	$ 0.01
Net income (loss) attributable to CVS Health	$ 5.08	$ (0.57)	$ 6.44	$ 4.90	$ 4.63
Dividends per common share	$ 2.00	$ 2.00	$ 2.00	$ 1.70	$ 1.40
Balance sheet and other data:					
Total assets	$ 222,449	$ 196,456	$ 95,131	$ 94,462	$ 92,437
Long-term debt, less current portion	$ 64,699	$ 71,444	$ 22,181	$ 25,615	$ 26,267
Total shareholders' equity	$ 64,170	$ 58,543	$ 37,695	$ 36,834	$ 37,203
Number of stores (at end of year)	9,941	9,967	9,846	9,750	9,681

(1) On November 28, 2018, the Company acquired Aetna. Aetna's operations are included in the Company's consolidated financial statements subsequent to the Aetna Acquisition Date. See Note 2 "Acquisitions and Divestitures" included in Item 8 of this 10-K for additional information.

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Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations. ("MD&A")

The following discussion and analysis should be read in conjunction with the audited consolidated financial statements and related notes included in Item 8 of this 10-K, "Risk Factors" included in Item 1A of this 10-K and the "Cautionary Statement Concerning Forward Looking Statements" in this 10-K.

Overview of Business

CVS Health Corporation ("CVS Health"), together with its subsidiaries (collectively, the "Company," "we," "our" or "us"), is the nation's premier health innovation company helping people on their path to better health. Whether in one of its pharmacies or through its health services and plans, CVS Health is pioneering a bold new approach to total health by making quality care more affordable, accessible, simple and seamless. CVS Health is community-based and locally focused, engaging consumers with the care they need when and where they need it. The Company has approximately 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 105 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year and expanding specialty pharmacy services. CVS Health also serves an estimated 37 million people through traditional, voluntary and consumer-directed health insurance products and related services, including expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

On November 28, 2018 (the "Aetna Acquisition Date"), the Company acquired Aetna Inc. ("Aetna") for a combination of cash and CVS Health stock (the "Aetna Acquisition"). The Company acquired Aetna to help improve the consumer health care experience by combining Aetna's health care benefits products and services with CVS Health's retail locations, walk-in medical clinics and integrated pharmacy capabilities with the goal of becoming the new, trusted front door to health care. Under the terms of the merger agreement, Aetna shareholders received $145.00 in cash and 0.8378 CVS Health shares for each Aetna share. The transaction valued Aetna at approximately $212 per share or approximately $70 billion. Including the assumption of Aetna's debt, the total value of the transaction was approximately $78 billion. The Company financed the cash portion of the purchase price through a combination of cash on hand and by issuing approximately $45 billion of new debt, including senior notes and term loans (see "Liquidity and Capital Resources" later in this MD&A). The consolidated financial statements reflect Aetna's results subsequent to the Aetna Acquisition Date.

On October 10, 2018, the Company and Aetna entered into a consent decree with the U.S. Department of Justice (the "DOJ") that allowed the Company's proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone PDPs. As part of the agreement reached with the DOJ, Aetna entered into a purchase agreement with a subsidiary of WellCare Health Plans, Inc. ("WellCare") for the divestiture of Aetna's standalone PDPs effective December 31, 2018. On November 30, 2018, the Company completed the sale of Aetna's standalone PDPs. The Company provided administrative services to, and retained the financial results of, the divested plans through 2019. Subsequent to 2019, the Company will no longer retain the financial results of the divested plans. Aetna's standalone PDPs had an aggregate of 2.5 million members as of December 31, 2019.

As a result of the Aetna Acquisition, the Company added the Health Care Benefits segment. Certain aspects of Aetna's operations, including products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, are included in the Company's Corporate/Other segment.

Effective for the first quarter of 2019, the Company realigned the composition of its segments to correspond with changes to its operating model and reflect how its Chief Operating Decision Maker (the "CODM") reviews information and manages the business. As a result of this realignment, the Company's SilverScript® PDP moved from the Pharmacy Services segment to the Health Care Benefits segment. In addition, the Company moved Aetna's mail order and specialty pharmacy operations from the Health Care Benefits segment to the Pharmacy Services segment. Segment financial information has been retrospectively adjusted to reflect these changes. See Note 17 "Segment Reporting" included in Item 8 of this 10-K for segment financial information.

The Company has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other, which are described below.

Overview of the Pharmacy Services Segment

The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services, mail order pharmacy, specialty pharmacy and infusion services, clinical services, disease management services and medical spend management. The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Medicaid managed care plans, plans offered on public health insurance exchanges and private health insurance exchanges, other sponsors of health benefit plans and individuals throughout the United States. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services. During the year ended December 31, 2019, the Company's PBM filled or managed 2.0 billion prescriptions on a 30-day equivalent basis.

Overview of the Retail/LTC Segment

The Retail/LTC segment sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products, cosmetics and personal care products, provides health care services through its MinuteClinic® walk-in medical clinics and conducts long-term care pharmacy ("LTC") operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. As of December 31, 2019, the Retail/LTC segment operated approximately 9,900 retail locations, approximately 1,100 MinuteClinic® locations as well as online retail pharmacy websites, LTC pharmacies and onsite pharmacies. During the year ended December 31, 2019, the Retail/LTC segment filled 1.4 billion prescriptions on a 30-day equivalent basis. For the year ended December 31, 2019, the Company dispensed approximately 26.6% of the total retail pharmacy prescriptions in the United States.

Overview of the Health Care Benefits Segment

The Health Care Benefits segment is one of the nation's leading diversified health care benefits providers, serving an estimated 37 million people as of December 31, 2019. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make more informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental and behavioral health plans, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services, workers' compensation administrative services and health information technology products and services. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates. The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk for medical and dental care costs) as "ASC." For periods prior to November 28, 2018 (the Aetna Acquisition Date), the Health Care Benefits segment was comprised of the Company's SilverScript PDP business.

Overview of the Corporate/Other Segment

The Company presents the remainder of its financial results in the Corporate/Other segment, which consists of:

- Management and administrative expenses to support the overall operations of the Company, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments, expenses associated with the Company's investments in its transformation and Enterprise modernization programs and acquisition-related transaction and integration costs; and

- Products for which the Company no longer solicits or accepts new customers such as large case pensions and long-term care insurance products.

Results of Operations

The following information summarizes the Company's results of operations for 2019 compared to 2018. For discussion of the Company's results of operations for 2018 compared to 2017, see "Management's Discussion and Analysis of Financial Condition and Results of Operations with Retrospective Application of Segments" for the year ended December 31, 2018, which was revised to reflect the Company's segment realignment and is included in Exhibit 99.2 to the Company's Current Report on Form 8-K filed with the U.S. Securities and Exchange Commission (the "SEC") on August 8, 2019.

Summary of Consolidated Financial Results

				Change			
	Year Ended December 31,			2019 vs. 2018		2018 vs. 2017	
In millions	**2019**	**2018**	**2017**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ 185,236	$ 183,910	$ 180,063	$ 1,326	0.7 %	$ 3,847	2.1 %
Premiums	63,122	8,184	3,558	54,938	671.3 %	4,626	130.0 %
Services	7,407	1,825	1,144	5,582	305.9 %	681	59.5 %
Net investment income	1,011	660	21	351	53.2 %	639	3,042.9 %
Total revenues	256,776	194,579	184,786	62,197	32.0 %	9,793	5.3 %
Operating costs:							
Cost of products sold	158,719	156,447	153,448	2,272	1.5 %	2,999	2.0 %
Benefit costs	52,529	6,594	2,810	45,935	696.6 %	3,784	134.7 %
Goodwill impairments	—	6,149	181	(6,149)	(100.0)%	5,968	3,297.2 %
Operating expenses	33,541	21,368	18,809	12,173	57.0 %	2,559	13.6 %
Total operating costs	244,789	190,558	175,248	54,231	28.5 %	15,310	8.7 %
Operating income	11,987	4,021	9,538	7,966	198.1 %	(5,517)	(57.8)%
Interest expense	3,035	2,619	1,062	416	15.9 %	1,557	146.6 %
Loss on early extinguishment of debt	79	—	—	79	100.0 %	—	— %
Other expense (income)	(124)	(4)	208	(120)	(3,000.0)%	(212)	(101.9)%
Income before income tax provision	8,997	1,406	8,268	7,591	539.9 %	(6,862)	(83.0)%
Income tax provision	2,366	2,002	1,637	364	18.2 %	365	22.3 %
Income (loss) from continuing operations	6,631	(596)	6,631	7,227	1,212.6 %	(7,227)	(109.0)%
Loss from discontinued operations, net of tax	—	—	(8)	—	— %	8	100.0 %
Net income (loss)	6,631	(596)	6,623	7,227	1,212.6 %	(7,219)	(109.0)%
Net (income) loss attributable to noncontrolling interests	3	2	(1)	1	50.0 %	3	300.0 %
Net income (loss) attributable to CVS Health	$ 6,634	$ (594)	$ 6,622	$ 7,228	1,216.8 %	$ (7,216)	(109.0)%

Commentary - 2019 compared to 2018

Revenues

- Total revenues increased $62.2 billion or 32.0% in 2019 compared to 2018. The increase in total revenues was primarily due to the impact of the Aetna Acquisition (primarily reflected in the Health Care Benefits segment)

which occurred in November 2018, a 5.0% increase in Pharmacy Services segment revenue and a 3.1% increase in Retail/LTC segment revenue.

- Please see "Segment Analysis" later in this MD&A for additional information about the revenues of the Company's segments.

Operating expenses

- Operating expenses increased $12.2 billion or 57.0% in 2019 compared to 2018. Operating expenses as a percentage of total revenues were 13.1% in 2019, an increase of 210 basis points compared to 2018. The increase in operating expenses was primarily due to the impact of the Aetna Acquisition (including intangible asset amortization) and higher operating

expenses in the Retail/LTC segment, including $231 million of store rationalization charges and the $205 million pre-tax loss on the sale of the Company's Brazilian subsidiary, Drogaria Onofre Ltda. ("Onofre"), both recorded in the year ended December 31, 2019.

- Please see "Segment Analysis" later in this MD&A for additional information about the operating expenses of the Company's segments.

Operating income

- Operating income increased $8.0 billion in 2019 compared to 2018. The increase was primarily due to (i) the absence of the $6.1 billion of pre-tax goodwill impairment charges related to the LTC reporting unit recorded within the Retail/LTC segment in 2018, (ii) the impact of the Aetna Acquisition and (iii) increased prescription volume and improved purchasing economics in the Pharmacy Services and Retail/LTC segments. The increase was partially offset by:
  - Continued reimbursement pressure in the Retail/LTC segment;
  - Continued price compression in the Pharmacy Services segment;
  - An increase in intangible asset amortization primarily related to the Aetna Acquisition;
  - Higher operating expenses in the Retail/LTC segment, including $231 million of store rationalization charges and the $205 million pre-tax loss on the sale of Onofre; and
  - The absence of $536 million in interest income on the proceeds from the financing for the Aetna Acquisition recorded in the year ended December 31, 2018.
- Please see "Segment Analysis" later in this MD&A for additional information about the operating income of the Company's segments.

Interest expense

- Interest expense increased $416 million in 2019 compared to 2018, primarily due to financing activity associated with the Aetna Acquisition and the assumption of Aetna's debt as of the Aetna Acquisition Date. See Note 8 "Borrowings and Credit Agreements" included in Item 8 of this 10-K for additional information.

Loss on early extinguishment of debt

- During 2019, the loss on early extinguishment of debt relates to the Company's repayment of $4.0 billion of its outstanding senior notes pursuant to its tender offers for such senior notes in August 2019, which resulted in a loss on early extinguishment of debt of $79 million. See Note 8 "Borrowings and Credit Agreements" included in Item 8 of this 10-K for additional information.

Other income

- Other income increased $120 million in 2019 compared to 2018. Other income represents pension plan asset returns in excess of interest cost on pension plan obligations. The increase in other income in 2019 was primarily due to 2019 including a full year of income associated with the Aetna pension plan, as compared to 2018 which only included the Aetna pension plan income for the period subsequent to the Aetna Acquisition Date.

Income tax provision

- The Company's effective income tax rate was 26.3% in 2019 compared to 142.4% in 2018. The decrease in the effective income tax rate was primarily due to the absence of the $6.1 billion of pre-tax goodwill impairment charges recorded during 2018, the majority of which were not deductible for income tax purposes.

Loss from discontinued operations

- In connection with certain business dispositions completed between 1995 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Linens 'n Things, which filed for bankruptcy in 2008, and Bob's Stores, which filed for bankruptcy in 2016. The Company's loss from discontinued operations primarily includes lease-related costs required to satisfy its Linens 'n Things and Bob's Stores lease guarantees.
-

See “Discontinued Operations” in Note 1 ‘‘Significant Accounting Policies’’ and “Lease Guarantees” in Note 16 ‘‘Commitments and Contingencies’’ included in Item 8 of this 10-K for additional information about the Company’s discontinued operations and the Company’s lease guarantees, respectively.

Outlook for 2020

With respect to 2020, the Company believes you should consider the following important information:

- The Pharmacy Services segment is expected to benefit from continued improvements in purchasing economics and Enterprise modernization, partially offset by net selling season losses during 2020 and continued price compression.

- The Retail/LTC segment is expected to benefit from projected adjusted script growth driven by the continued successful execution of patient care programs, partially offset by continued reimbursement pressure.

- The Health Care Benefits segment is expected to benefit from Government Services membership growth including projected above-industry growth in its Medicare Advantage products and new Medicaid contract wins, as well as integration synergies that will continue to disproportionately benefit the Health Care Benefits segment.

- The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA") imposes a significant industry-wide fee known as the Health Insurer Fee (the "HIF"). The HIF is non-deductible for federal income tax purposes and is allocated to insurers based on the ratio of the amount of an insurer's net premium revenues written during the preceding calendar year to the amount of health insurance premium for all U.S. health risk for certain lines of business during the preceding calendar year. The HIF was suspended for 2019, will be $15.5 billion for 2020 and has been repealed for calendar years after 2020. While the Company expects the reintroduction of the HIF to result in a lower medical benefit ratio ("MBR") in 2020 compared to 2019, all else being equal, the Company expects its 2020 consolidated net income will be negatively impacted due to an increase in its effective income tax rate in 2020 compared to 2019 as a result of the non-deductibility of the HIF.

- The Company believes that it is on track to achieve its 2020 target of $800-900 million of synergies from the Aetna Acquisition.

- The Company expects changes to its business environment to continue for the next several years as elected and other government officials at the national and state levels continue to propose and enact significant modifications to public policy and existing laws and regulations that govern the Company's businesses.

The Company's current expectations described above are forward-looking statements. Please see "Risk Factors" in Item 1A of this 10-K for information regarding important factors that may cause the Company's actual results to differ from those currently projected and/or otherwise materially affect the Company.

Segment Analysis

The following discussion of segment operating results is presented based on the Company's reportable segments in accordance with the accounting guidance for segment reporting and is consistent with the segment disclosure in Note 17 "Segment Reporting" included in Item 8 of this 10-K.

The Company has three operating segments, Pharmacy Services, Retail/LTC and Health Care Benefits, as well as a Corporate/Other segment. The Company's segments maintain separate financial information, and the CODM evaluates the segments' operating results on a regular basis in deciding how to allocate resources among the segments and in assessing segment performance. The CODM evaluates the performance of the Company's segments based on adjusted operating income. Effective for the first quarter of 2019, adjusted operating income is defined as operating income (GAAP measure) excluding the impact of amortization of intangible assets and other items, if any, that neither relate to the ordinary course of the Company's business nor reflect the Company's underlying business performance. Segment financial information has been retrospectively adjusted to conform with the current period presentation. See the reconciliations of operating income (GAAP measure) to adjusted operating income below for further context regarding the items excluded from operating income in determining adjusted operating income. The Company uses adjusted operating income as its principal measure of segment performance as it enhances the Company's ability to compare past financial performance with current performance and analyze underlying business performance and trends. Non-GAAP financial measures the Company discloses, such as consolidated adjusted operating income, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

Effective for the first quarter of 2019, the Company realigned the composition of its segments to correspond with changes to its operating model and reflect how the CODM reviews information and manages the business. See Note 1 "Significant Accounting Policies" included in Item 8 of this 10-K for further discussion of this realignment. Segment financial information has been retrospectively adjusted to reflect these changes.

The following is a reconciliation of financial measures of the Company's segments to the consolidated totals:

In millions	**Pharmacy Services [1]**	**Retail/ LTC**	**Health Care Benefits**	**Corporate/ Other**	**Intersegment Eliminations [2]**	**Consolidated Totals**
2019						
Total revenues	$ 141,491	$ 86,608	$ 69,604	$ 512	$ (41,439)	$ 256,776
Adjusted operating income (loss)	5,129	6,705	5,202	(1,000)	(697)	15,339
2018						
Total revenues	134,736	83,989	8,962	606	(33,714)	194,579
Adjusted operating income (loss)	4,955	7,403	528	(856)	(769)	11,261
2017						
Total revenues	130,822	79,398	3,587	16	(29,037)	184,786
Adjusted operating income (loss)	4,628	7,475	359	(896)	(741)	10,825

(1) Total revenues of the Pharmacy Services segment include approximately $11.5 billion, $11.4 billion and $10.8 billion of retail co-payments for 2019, 2018 and 2017, respectively. See Note 1 "Significant Accounting Policies" included in Item 8 of this 10-K for additional information about retail co-payments.

(2) Intersegment eliminations relate to intersegment revenue generating activities that occur between the Pharmacy Services segment, the Retail/LTC segment and/or the Health Care Benefits segment.

The following is a reconciliation of operating income to adjusted operating income for the years ended December 31, 2019, 2018 and 2017:

	Year Ended December 31, 2019					
In millions	**Pharmacy Services**	**Retail/ LTC**	**Health Care Benefits**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Operating income (loss) (GAAP measure)	$ 4,735	$ 5,793	$ 3,639	$ (1,483)	$ (697)	$ 11,987
Non-GAAP adjustments:						
Amortization of intangible assets [(1)]	394	476	1,563	3	—	2,436
Acquisition-related integration costs [(2)]	—	—	—	480	—	480
Store rationalization charges [(3)]	—	231	—	—	—	231
Loss on divestiture of subsidiary [(4)]	—	205	—	—	—	205
Adjusted operating income (loss)	$ 5,129	$ 6,705	$ 5,202	$ (1,000)	$ (697)	$ 15,339

	Year Ended December 31, 2018					
In millions	**Pharmacy Services**	**Retail/ LTC**	**Health Care Benefits**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Operating income (loss) (GAAP measure)	$ 4,607	$ 620	$ 368	$ (805)	$ (769)	$ 4,021
Non-GAAP adjustments:						
Amortization of intangible assets [(1)]	348	498	160	—	—	1,006
Acquisition-related transaction and integration costs [(2)]	—	7	—	485	—	492
Loss on divestiture of subsidiary [(4)]	—	86	—	—	—	86
Goodwill impairments [(5)]	—	6,149	—	—	—	6,149
Impairment of long-lived assets [(6)]	—	43	—	—	—	43
Interest income on financing for the Aetna Acquisition [(7)]	—	—	—	(536)	—	(536)
Adjusted operating income (loss)	$ 4,955	$ 7,403	$ 528	$ (856)	$ (769)	$ 11,261

In millions	Year Ended December 31, 2017					
	Pharmacy Services	Retail/ LTC	Health Care Benefits	Corporate/ Other	Intersegment Eliminations	Consolidated Totals
Operating income (loss) (GAAP measure)	$ 4,300	$ 6,558	$ 357	$ (936)	$ (741)	$ 9,538
Non-GAAP adjustments:						
Amortization of intangible assets (1)	328	487	2	—	—	817
Acquisition-related transaction and integration costs (2)	—	34	—	31	—	65
Store rationalization charges (3)	—	215	—	—	—	215
Loss on divestiture of subsidiary (4)	—	—	—	9	—	9
Goodwill impairments (5)	—	181	—	—	—	181
Adjusted operating income (loss)	$ 4,628	$ 7,475	$ 359	$ (896)	$ (741)	$ 10,825

(1) The Company's acquisition activities have resulted in the recognition of intangible assets as required under the acquisition method of accounting which consist primarily of trademarks, customer contracts/relationships, covenants not to compete, technology, provider networks and value of business acquired. Definite-lived intangible assets are amortized over their estimated useful lives and are tested for impairment when events indicate that the carrying value may not be recoverable. The amortization of intangible assets is reflected in the Company's statements of operations in operating expenses within each segment. Although intangible assets contribute to the Company's revenue generation, the amortization of intangible assets does not directly relate to the underwriting of the Company's insurance products, the services performed for the Company's customers or the sale of the Company's products or services. Additionally, intangible asset amortization expense typically fluctuates based on the size and timing of the Company's acquisition activity. Accordingly, the Company believes excluding the amortization of intangible assets enhances the Company's and investors' ability to compare the Company's past financial performance with its current performance and to analyze underlying business performance and trends. Intangible asset amortization excluded from the related non-GAAP financial measure represents the entire amount recorded within the Company's GAAP financial statements, and the revenue generated by the associated intangible assets has not been excluded from the related non-GAAP financial measure. Intangible asset amortization is excluded from the related non-GAAP financial measure because the amortization, unlike the related revenue, is not affected by operations of any particular period unless an intangible asset becomes impaired or the estimated useful life of an intangible asset is revised.

(2) In 2019, 2018 and 2017, acquisition-related transaction and integration costs relate to the Aetna Acquisition. In 2018 and 2017, acquisition-related transaction and integration costs also relate to the acquisition of Omnicare, Inc. ("Omnicare"). The acquisition-related transaction and integration costs are reflected in the Company's consolidated statements of operations in operating expenses within the Corporate/Other segment and the Retail/LTC segment.

(3) In 2019, the store rationalization charges relate to the planned closure of 46 underperforming retail pharmacy stores during the second quarter of 2019 and the planned closure of 22 underperforming retail pharmacy stores during the first quarter of 2020. In 2019, the store rationalization charges primarily relate to operating lease right-of-use asset impairment charges and are reflected in the Company's consolidated statements of operations in operating expenses within the Retail/LTC segment. In 2017, the store rationalization charges related to the Company's enterprise streamlining initiative and are reflected in the Company's consolidated statements of operations in operating expenses within the Retail/LTC segment.

(4) In 2019, the loss on divestiture of subsidiary represents the pre-tax loss on the sale of Onofre, which occurred on July 1, 2019. The loss on divestiture primarily relates to the elimination of the cumulative translation adjustment from accumulated other comprehensive income. In 2018, the loss on divestiture of subsidiary represents the pre-tax loss on the sale of the Company's RxCrossroads subsidiary for $725 million on January 2, 2018. In 2017, the loss on divestiture of subsidiary represents transaction costs associated with the sale of RxCrossroads. The loss on divestiture of subsidiary costs are reflected in the Company's consolidated statements of operations in operating expenses within the Retail/LTC segment and Corporate/Other segment.

(5) In 2018, the goodwill impairments relate to the LTC reporting unit within the Retail/LTC segment. In 2017, the goodwill impairments relate to the RxCrossroads reporting unit within the Retail/LTC segment.

(6) In 2018, impairment of long-lived assets primarily relates to the impairment of property and equipment within the Retail/LTC segment and is reflected in operating expenses in the Company's consolidated statements of operations.

(7) In 2018, the Company recorded interest income of $536 million on the proceeds of the $40 billion of unsecured senior notes it issued in March 2018 to partially fund the Aetna Acquisition. All amounts are for the periods prior to the close of the Aetna Acquisition, which occurred on November 28, 2018, and were recorded within the Corporate/Other segment.

Pharmacy Services Segment

The following table summarizes the Pharmacy Services segment's performance for the respective periods:

	Year Ended December 31,			Change			
				2019 vs. 2018		2018 vs. 2017	
In millions, except percentages	**2019**	**2018**	**2017**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ 140,946	$ 134,285	$ 130,578	$ 6,661	5.0 %	$ 3,707	2.8 %
Services	545	451	244	94	20.8 %	207	84.8 %
Total revenues	141,491	134,736	130,822	6,755	5.0 %	3,914	3.0 %
Cost of products sold	135,245	128,777	125,273	6,468	5.0 %	3,504	2.8 %
Operating expenses	1,511	1,352	1,249	159	11.8 %	103	8.2 %
Operating expenses as a % of total revenues	1.1 %	1.0 %	1.0 %				
Operating income	$ 4,735	$ 4,607	$ 4,300	$ 128	2.8 %	$ 307	7.1 %
Operating income as a % of total revenues	3.3 %	3.4 %	3.3 %				
Adjusted operating income [1]	$ 5,129	$ 4,955	$ 4,628	$ 174	3.5 %	$ 327	7.1 %
Adjusted operating income as a % of total revenues	3.6 %	3.7 %	3.5 %				
Revenues (by distribution channel):							
Pharmacy network [2] [3]	$ 88,755	$ 87,167	$ 84,677	$ 1,588	1.8 %	$ 2,490	2.9 %
Mail choice [3] [4]	52,141	47,049	45,731	5,092	10.8 %	1,318	2.9 %
Other	595	520	414	75	14.4 %	106	25.6 %
Pharmacy claims processed: [5]							
Total	2,014.2	1,889.8	1,781.9	124.4	6.6 %	107.9	6.1 %
Pharmacy network [2]	1,704.0	1,601.4	1,516.7	102.6	6.4 %	84.7	5.6 %
Mail choice [4]	310.2	288.4	265.2	21.8	7.6 %	23.2	8.7 %
Generic dispensing rate: [5]							
Total	88.2 %	87.3 %	87.0 %				
Pharmacy network [2]	88.7 %	87.9 %	87.7 %				
Mail choice [4]	85.1 %	83.9 %	83.1 %				
Mail choice penetration rate [4] [5]	15.4 %	15.3 %	14.9 %				

(1) See "Segment Analysis" above in this MD&A for a reconciliation of operating income (GAAP measure) to adjusted operating income for the Pharmacy Services segment.

(2) Pharmacy network revenues, pharmacy claims processed and generic dispensing rate do not include Maintenance Choice® activity, which is included within the mail choice category. Pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including the Company's retail pharmacies and LTC pharmacies, but excluding Maintenance Choice activity, which is included within the mail choice category. Maintenance choice permits eligible client plan members to fill their maintenance prescriptions through mail order delivery or at a CVS pharmacy retail store for the same price as mail order.

(3) Certain prior year amounts have been reclassified for consistency with the current period presentation.

(4) Mail choice is defined as claims filled at a Pharmacy Services mail order facility, which includes specialty mail claims inclusive of Specialty Connect® claims picked up at a retail pharmacy, as well as prescriptions filled at the Company's retail pharmacies under the Maintenance Choice program.

(5) Includes an adjustment to convert 90-day prescriptions to the equivalent of three 30-day prescriptions. This adjustment reflects the fact that these prescriptions include approximately three times the amount of product days supplied compared to a normal prescription.

Commentary - 2019 compared to 2018

Revenues

- Total revenues increased $6.8 billion, or 5.0%, to $141.5 billion in 2019 compared to 2018. The increase was primarily due to brand inflation as well as increased total pharmacy claims volume, partially offset by continued price compression and an increased generic dispensing rate.

- As you review the Pharmacy Services segment's performance in this area, you should consider the following important information about the business:

    - The Company's mail choice claims processed, on a 30-day equivalent basis, increased 7.6% to 310.2 million claims in 2019 compared to 288.4 million claims in 2018. The increase in mail choice claims was primarily driven by the continued adoption of Maintenance Choice offerings.

    - During 2019, the average revenue per mail choice claim, on a 30-day equivalent basis, increased by 3.0% compared to 2018 primarily due to growth in specialty pharmacy claims processed.

    - The Company's pharmacy network claims processed, on a 30-day equivalent basis, increased 6.4% to 1.7 billion claims in 2019 compared to 1.6 billion claims in 2018. The increase in the pharmacy network claim volume was primarily due to net new business, including the onboarding of Anthem, Inc.'s ("Anthem's") PBM, IngenioRx, during 2019.

    - During 2019, the average revenue per pharmacy network claim processed, on a 30-day equivalent basis, decreased 4.2% compared to 2018 as a result of continued price compression.

    - The segment's total generic dispensing rate increased to 88.2% in 2019 compared to 87.3% in 2018. The continued increase in the segment's generic dispensing rate was primarily due to the impact of new generic drug introductions and the Company's ongoing efforts to encourage plan members to use generic drugs when they are available and clinically appropriate. The Company believes its generic dispensing rate will continue to increase in future periods, albeit at a slower pace. This increase will be affected by, among other things, the number of new brand and generic drug introductions and the Company's success at encouraging plan members to utilize generic drugs when they are available and clinically appropriate.

Operating expenses

- Operating expenses in the Pharmacy Services segment include selling, general and administrative expenses; depreciation and amortization related to selling, general and administrative activities; and expenses related to specialty retail pharmacies, which include store and administrative payroll, employee benefits and occupancy costs.

- Operating expenses increased $159 million, or 11.8%, in 2019 compared to 2018. The increase in operating expenses was primarily due to growth in the business, including operating expenses associated with Aetna's mail order and specialty pharmacy operations (including intangible asset amortization) and investments related to the Company's agreement with Anthem's PBM, IngenioRx, during 2019.

- Operating expenses as a percentage of total revenues remained relatively consistent at 1.1% and 1.0% in 2019 and 2018, respectively.

Operating income and adjusted operating income

- Operating income increased $128 million, or 2.8%, and adjusted operating income increased $174 million, or 3.5%, in 2019 compared to 2018. The increase in both operating income and adjusted operating income was primarily driven by increased claims volume, the addition of Aetna's mail order and specialty pharmacy operations and improved purchasing economics, partially offset by continued price compression. The increase in operating income also was partially offset by increased intangible asset amortization related to Aetna's mail order and specialty pharmacy operations.

- As you review the Pharmacy Services segment's performance in this area, you should consider the following important information about the business:

- The Company's efforts to (i) retain existing clients, (ii) obtain new business and (iii) maintain or improve the rebates and/or discounts the Company receives from manufacturers, wholesalers and retail pharmacies continue to have an impact on operating income and adjusted operating income. In particular, competitive pressures in the PBM industry have caused the Company and other PBMs to continue to share with clients a larger portion of rebates and/or discounts received from pharmaceutical manufacturers. In addition, marketplace dynamics and regulatory changes have limited the Company's ability to offer plan sponsors pricing that includes retail network "differential" or "spread," and the Company expects these trends to continue. The "differential" or "spread" is any difference between the drug price charged to plan sponsors, including Medicare Part D plan sponsors, by a PBM and the price paid for the drug by the PBM to the dispensing provider.

Retail/LTC Segment

The following table summarizes the Retail/LTC segment's performance for the respective periods:

	Year Ended December 31,			Change			
				2019 vs. 2018		2018 vs. 2017	
In millions, except percentages	**2019**	**2018**	**2017**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ 85,729	$ 83,175	$ 78,522	$ 2,554	3.1 %	$ 4,653	5.9 %
Services	879	814	876	65	8.0 %	(62)	(7.1)%
Total revenues	86,608	83,989	79,398	2,619	3.1 %	4,591	5.8 %
Cost of products sold	62,688	59,906	56,066	2,782	4.6 %	3,840	6.8 %
Goodwill impairments	—	6,149	181	(6,149)	(100.0)%	5,968	3,297.2 %
Operating expenses	18,127	17,314	16,593	813	4.7 %	721	4.3 %
Operating expenses as a % of total revenues	20.9%	20.6%	20.9 %				
Operating income	$ 5,793	$ 620	$ 6,558	$ 5,173	834.4 %	$ (5,938)	(90.5)%
Operating income as a % of total revenues	6.7%	0.7%	8.3 %				
Adjusted operating income [1]	$ 6,705	$ 7,403	$ 7,475	$ (698)	(9.4)%	$ (72)	(1.0)%
Adjusted operating income as a % of total revenues	7.7%	8.8%	9.4 %				
Revenues (by major goods/ service lines):							
Pharmacy	$ 66,442	$ 64,179	$ 59,528	$ 2,263	3.5 %	$ 4,651	7.8 %
Front Store	19,422	19,055	18,769	367	1.9 %	286	1.5 %
Other	744	755	1,101	(11)	(1.5)%	(346)	(31.4)%
Prescriptions filled [2]	1,417.2	1,339.1	1,230.5	78.1	5.8 %	108.6	8.8 %
Revenues increase (decrease):							
Total	3.1%	5.8%	(2.1)%				
Pharmacy	3.5%	7.8%	(2.2)%				
Front Store	1.9%	1.5%	(1.9)%				
Total prescription volume increase [2]	5.8%	8.8%	0.6 %				
Same store sales increase (decrease): [3]							
Total	3.7%	6.0%	(2.6)%				
Pharmacy	4.5%	7.9%	(2.6)%				
Front Store	1.1%	0.5%	(2.6)%				
Prescription volume [2]	7.2%	9.1%	0.4 %				
Generic dispensing rate [2]	88.3%	87.5%	87.3 %				

(1) See “Segment Analysis” above in this MD&A for a reconciliation of operating income (GAAP measure) to adjusted operating income for the Retail/LTC segment.

(2) Includes an adjustment to convert 90-day prescriptions to the equivalent of three 30-day prescriptions. This adjustment reflects the fact that these prescriptions include approximately three times the amount of product days supplied compared to a normal prescription.

(3) Same store sales and prescription volume exclude revenues from MinuteClinic, and revenue and prescriptions from stores in Brazil and LTC operations.

Commentary - 2019 compared to 2018

Revenues

- Total revenues increased approximately $2.6 billion, or 3.1%, to $86.6 billion in 2019 compared to 2018. The increase was primarily driven by increased prescription volume and brand inflation, partially offset by continued reimbursement pressure and an increased generic dispensing rate.

- As you review the Retail/LTC segment's performance in this area, you should consider the following important information about the business:

    - Front store same store sales increased 1.1% in 2019 compared to 2018. The increase in front store sales in 2019 was primarily driven by increases in health and beauty product sales.

    - Pharmacy same store sales increased 4.5% in 2019 compared to 2018. The increase was primarily driven by the 7.2% increase in pharmacy same store prescription volumes on a 30-day equivalent basis driven mainly by (i) continued adoption of patient care programs, (ii) collaborations with PBMs and (iii) the Company's preferred status in a number of Medicare Part D networks.

    - Pharmacy revenue growth continues to be adversely affected by reimbursement pressure. Pharmacy revenue growth also continues to be adversely affected by the conversion of brand name drugs to equivalent generic drugs, which typically have a lower selling price. The segment's generic dispensing rate grew to 88.3% in 2019 compared to 87.5% in 2018.

    - Pharmacy revenue growth also continues to be adversely affected by industry challenges in the LTC business, such as continuing lower occupancy rates at skilled nursing facilities, as well as the deteriorating financial health of many skilled nursing facilities.

    - Pharmacy revenue in 2019 continued to benefit from the Company's ability to attract and retain managed care customers and the increased use of pharmaceuticals by an aging population as the first line of defense for health care.

Operating expenses

- Operating expenses in the Retail/LTC segment include store payroll, store employee benefits, store occupancy costs, selling expenses, advertising expenses, depreciation and amortization expense and certain administrative expenses.

- Operating expenses increased $813 million, or 4.7%, in 2019 compared to 2018, primarily due to the following:

    - Store rationalization charges of $231 million recorded in 2019 primarily related to operating lease right-of-use asset impairment charges in connection with the planned closure of underperforming retail pharmacy stores during the second quarter of 2019 and the first quarter of 2020;

    - The $205 million pre-tax loss on the sale of Onofre, which occurred on July 1, 2019;

    - The increased prescription volume described above; and

    - The investment of a portion of the savings from the Tax Cuts and Jobs Act (the "TCJA") in wages and benefits.

- Operating expenses as a percentage of total revenues were 20.9% in 2019 compared to 20.6% in 2018. The increase in operating expenses as a percentage of total revenues was primarily driven by the increases in operating expenses described above.

Operating income and adjusted operating income

- Operating income increased $5.2 billion in 2019 compared to 2018. The increase in operating income was primarily due to the absence of the $6.1 billion of pre-tax goodwill impairment charges related to the LTC reporting unit recorded in the year ended December 31, 2018, partially offset by the decrease in adjusted operating income described below, as well as the $231 million of store rationalization charges and the $205 million pre-tax loss on the sale of Onofre, both recorded in 2019.

- Adjusted operating income decreased $698 million, or 9.4%, in 2019 compared to 2018. The decrease in adjusted operating income was primarily due to continued reimbursement pressure and increased operating expenses primarily driven by the investment of a portion of the savings from the TCJA in wages and benefits. The decrease was partially offset by increased prescription volume, an increased generic dispensing rate and improved purchasing economics.

- As you review the Retail/LTC segment's performance in this area, you should consider the following important information about the business:
    - The segment's pharmacy operating income and adjusted operating income has been adversely affected by the efforts of managed care organizations, PBMs and governmental and other third-party payors to reduce their prescription drug costs, including the use of restrictive networks, as well as changes in the mix of business within the pharmacy portion of the Retail/LTC segment. If the reimbursement pressure accelerates, the segment may not be able grow revenues, and its operating income and adjusted operating income could be adversely affected.
    - The increased use of generic drugs has positively impacted the segment's operating income and adjusted operating income but has resulted in third-party payors augmenting their efforts to reduce reimbursement payments to retail pharmacies for prescriptions. This trend, which the Company expects to continue, reduces the benefit the segment realizes from brand to generic drug conversions.

Health Care Benefits Segment

For periods prior to November 28, 2018 (the Aetna Acquisition Date), the Health Care Benefits segment was comprised of the Company's SilverScript PDP business. The following table summarizes the Health Care Benefits segment's performance for the respective periods:

				Change			
	Year Ended December 31,			2019 vs. 2018		2018 vs. 2017	
In millions, except percentages	**2019**	**2018**	**2017**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ —	$ 164	$ —	$ (164)	(100.0)%	$ 164	100.0 %
Premiums	63,031	8,180	3,558	54,851	670.6 %	4,622	129.9 %
Services	5,974	560	24	5,414	966.8 %	536	2,233.3 %
Net investment income	599	58	5	541	932.8 %	53	1,060.0 %
Total revenues	69,604	8,962	3,587	60,642	676.7 %	5,375	149.8 %
Cost of products sold	—	147	—	(147)	(100.0)%	147	100.0 %
Benefit costs	53,092	6,678	2,810	46,414	695.0 %	3,868	137.7 %
MBR (Benefit costs as a % of premium revenues) (1)	84.2 %	NM	NM				
Operating expenses	$ 12,873	$ 1,769	$ 420	$ 11,104	627.7 %	$ 1,349	321.2 %
Operating expenses as a % of total revenues	18.5 %	19.7 %	11.7 %				
Operating income	$ 3,639	$ 368	$ 357	$ 3,271	888.9 %	$ 11	3.1 %
Operating income as a % of total revenues	5.2 %	4.1 %	10.0 %				
Adjusted operating income (2)	$ 5,202	$ 528	$ 359	$ 4,674	885.2 %	$ 169	47.1 %
Adjusted operating income as a % of total revenues	7.5 %	5.9 %	10.0 %				

(1) For periods prior to the Aetna Acquisition Date, the Health Care Benefits segment was comprised of the Company's SilverScript PDP business. Accordingly, the MBR for the years ended December 31, 2018 and 2017 are not meaningful ("NM") and are not directly comparable to the MBRs for the year ended December 31, 2019.

(2) See "Segment Analysis" above in this MD&A for a reconciliation of operating income (GAAP measure) to adjusted operating income for the Health Care Benefits segment.

Commentary - 2019 compared to 2018

Revenues

- Total revenues increased $60.6 billion in 2019 compared to 2018 primarily due to the Aetna Acquisition.

Operating expenses

- Operating expenses in the Health Care Benefits segment include selling, general and administrative expenses and depreciation and amortization expenses.

- Operating expenses increased $11.1 billion in 2019 compared to 2018 primarily due to the Aetna Acquisition (including the amortization of intangible assets).

Operating income and adjusted operating income

- Operating income increased $3.3 billion and adjusted operating income increased $4.7 billion in 2019 compared to 2018. The increases were primarily due to the Aetna Acquisition. The increase in operating income was partially offset by increased intangible asset amortization related to the Aetna Acquisition.

The following table summarizes the Health Care Benefits segment's medical membership as of December 31, 2019 and 2018:

	2019			2018		
In thousands	**Insured**	**ASC**	**Total**	**Insured**	**ASC**	**Total**
Medical membership:						
Commercial	3,591	14,159	17,750	3,871	13,888	17,759
Medicare Advantage	2,321	—	2,321	1,758	—	1,758
Medicare Supplement	881	—	881	793	—	793
Medicaid	1,398	558	1,956	1,128	663	1,791
Total medical membership	8,191	14,717	22,908	7,550	14,551	22,101
Supplemental membership information:						
Medicare Prescription Drug Plan (standalone) (1)			5,994			6,134

(1) Represents the Company's SilverScript PDP membership only. Excludes 2.5 million and 2.3 million members as of December 31, 2019 and 2018, respectively, related to Aetna's standalone PDPs that were sold effective December 31, 2018. The Company retained the financial results of the divested plans through 2019 through a reinsurance agreement. Subsequent to 2019, the Company will no longer retain the financial results of the divested plans.

Medical Membership
Medical membership as of December 31, 2019 increased compared with December 31, 2018, reflecting increases in Medicare, Commercial ASC and Medicaid products, partially offset by declines in Commercial Insured products.

Medicare Update
On April 1, 2019, the U.S. Centers for Medicare & Medicaid Services ("CMS") issued its final notice detailing final 2020 Medicare Advantage benchmark payment rates (the "Final Notice"). Overall the Company projects the benchmark rates in the Final Notice will increase funding for its Medicare Advantage business, excluding the impact of the health insurer fee, by approximately 2.0% in 2020 compared to 2019.

The ACA ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star ratings." Plans must have a star rating of four or higher (out of five) to qualify for bonus payments. CMS released the Company's 2020 star ratings in October 2019. The Company's 2020 star ratings will be used to determine which of the Company's Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2021. Based on the Company's membership at December 31, 2019, 83% of the Company's Medicare Advantage members were in plans with 2020 star ratings of at least 4.0 stars, compared to 79% of the Company's Medicare Advantage members being in plans with 2019 star ratings of at least 4.0 stars based on the Company's membership at December 31, 2018.

Corporate/Other Segment

Commentary - 2019 compared to 2018

Revenues

- Total revenues decreased $94 million in 2019 compared to 2018.

- In 2019, revenues relate to products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, that were acquired in the Aetna Acquisition. Revenues in 2019 include $104 million of net realized capital gains, primarily related to the sale of debt securities and other invested assets that support these insurance products. In 2018, revenues relate to interest income on the proceeds from the financing of the Aetna Acquisition.

Operating expenses

- Operating expenses within the Corporate/Other segment include certain aspects of costs related to executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments, expenses associated with the Company's investments in its transformation and Enterprise

modernization programs and acquisition-related transaction and integration costs. After the Aetna Acquisition Date, such operating expenses also include operating costs to support the large case pensions and long-term care insurance products acquired in the Aetna Acquisition.

- Operating expenses increased $321 million in 2019 compared to 2018. The increase was primarily driven by growth in the business, incremental operating expenses associated with the Company's investments in transformation and Enterprise modernization, legal costs and a $30 million charitable contribution to the CVS Health Foundation in 2019.

Liquidity and Capital Resources

Cash Flows

The Company maintains a level of liquidity sufficient to allow it to meet its cash needs in the short-term. Over the long term, the Company manages its cash and capital structure to maximize shareholder return, maintain its financial condition and maintain flexibility for future strategic initiatives. The Company continuously assesses its regulatory capital requirements, working capital needs, debt and leverage levels, debt maturity schedule, capital expenditure requirements, dividend payouts, potential share repurchases and future investments or acquisitions. The Company believes its operating cash flows, commercial paper program, credit facilities, sale-leaseback program, as well as any potential future borrowings, will be sufficient to fund these future payments and long-term initiatives. As of December 31, 2019, the Company had approximately $5.7 billion in cash and cash equivalents, approximately $1.7 billion of which was held by the parent company or nonrestricted subsidiaries.

The net change in cash, cash equivalents and restricted cash for the years ended December 31, 2019, 2018 and 2017 is as follows:

				Change			
	Year Ended December 31,			2019 vs. 2018		2018 vs. 2017	
In millions	2019	2018	2017	$	%	$	%
Net cash provided by operating activities	$ 12,848	$ 8,865	$ 8,007	$ 3,983	44.9 %	$ 858	10.7 %
Net cash used in investing activities	(3,339)	(43,285)	(2,877)	39,946	(92.3 %)	(40,408)	1,404.5 %
Net cash provided by (used in) financing activities	(7,850)	36,819	(6,751)	(44,669)	(121.3 %)	43,570	(645.4 %)
Effect of exchange rate changes on cash, cash equivalents and restricted cash	—	(4)	1	4	(100.0 %)	(5)	(500.0 %)
Net increase (decrease) in cash, cash equivalents and restricted cash	$ 1,659	$ 2,395	$ (1,620)	$ (736)	(30.7 %)	$ 4,015	(247.8 %)

Commentary - 2019 compared to 2018

- *Net cash provided by operating activities* increased by $4.0 billion in 2019 compared to 2018 due primarily to the Aetna Acquisition as well as improvements in working capital, including the timing of certain payables and receipts.

- *Net cash used in investing activities* decreased by $39.9 billion in 2019 compared to 2018 largely due to the Aetna Acquisition in November 2018. The decrease was partially offset by the absence of the $725 million in proceeds from the sale of RxCrossroads in 2018 and net purchases of investments in 2019 compared to net sales of investments in 2018.

- *Net cash used in financing activities* was $7.9 billion in 2019 compared to net cash provided by financing activities of $36.8 billion in 2018. The decrease in cash provided by financing activities primarily related to long-term borrowings during 2018 to partially fund the Aetna Acquisition, as well as debt repayments during 2019 including (i) the repayment of $4.0 billion of outstanding senior notes pursuant to tender offers for such outstanding senior notes, (ii) the repayment of the remaining $3.0 billion of the term loan used to partially fund the Aetna Acquisition and (iii) the repayment of $1.2 billion aggregate principal amount of senior notes upon maturity. The decrease was partially offset by the issuance of $3.5 billion of senior notes in 2019.

Included in net cash used in investing activities for the years ended December 31, 2019, 2018 and 2017 was the following store development activity: (1)

	2019	2018	2017
Total stores (beginning of year)	9,967	9,846	9,750
New and acquired stores (2)	102	148	179
Closed stores (2)	(128)	(27)	(83)
Total stores (end of year)	9,941	9,967	9,846
Relocated stores (2)	23	34	30

(1) Includes retail drugstores, certain onsite pharmacy stores, retail specialty pharmacy stores and pharmacies within Target stores.

(2) Relocated stores are not included in new and acquired stores or closed stores totals.

Short-term Borrowings

Commercial Paper and Back-up Credit Facilities
The Company did not have any commercial paper outstanding as of December 31, 2019. The Company had $720 million of commercial paper outstanding at a weighted average interest rate of 2.8% as of December 31, 2018. In connection with its commercial paper program, the Company maintains a $1.0 billion 364-day unsecured back-up revolving credit facility, which expires on May 14, 2020, a $1.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 18, 2022, a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 17, 2023 and a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 16, 2024. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately .03%, regardless of usage. As of December 31, 2019 and 2018, there were no borrowings outstanding under any of the Company's back-up credit facilities.

Bridge Loan Facility
On December 3, 2017, in connection with the Aetna Acquisition, the Company entered into a $49.0 billion unsecured bridge loan facility commitment. The Company paid $221 million in fees upon entering into the agreement. The fees were capitalized in other current assets and were amortized as interest expense over the period the bridge loan facility commitment was outstanding. The bridge loan facility commitment was reduced to $44.0 billion on December 15, 2017 upon the Company entering into a $5.0 billion term loan agreement. The Company recorded $56 million of amortization of the bridge loan facility fees during the year ended December 31, 2017, which was recorded in interest expense in the consolidated statement of operations.

On March 9, 2018, the Company issued senior notes with an aggregate principal amount of $40.0 billion (see "Long-term Borrowings - 2018 Notes" below). At that time, the bridge loan facility commitment was reduced to $4.0 billion, and the Company paid $8 million in fees to retain the bridge loan facility commitment through the Aetna Acquisition Date. Those fees were capitalized in other current assets and were amortized as interest expense over the period the bridge loan facility commitment was outstanding. The Company recorded $173 million of amortization of the bridge loan facility commitment fees during the year ended December 31, 2018, which was recorded in interest expense in the consolidated statement of operations. On October 26, 2018, the Company entered into a $4.0 billion unsecured 364-day bridge term loan agreement to formalize the bridge loan facility discussed above. On November 28, 2018, in connection with the Aetna Acquisition, the $4.0 billion unsecured 364-day bridge term loan agreement terminated.

Federal Home Loan Bank of Boston
Since the Aetna Acquisition Date, a subsidiary of the Company is a member of the Federal Home Loan Bank of Boston (the "FHLBB"). As a member, the subsidiary has the ability to obtain cash advances, subject to certain minimum collateral requirements. The maximum borrowing capacity available from the FHLBB as of December 31, 2019 was approximately $850 million. At both December 31, 2019 and 2018, there were no outstanding advances from the FHLBB.

Long-term Borrowings

2019 Notes

On August 15, 2019, the Company issued $1.0 billion aggregate principal amount of 2.625% unsecured senior notes due August 15, 2024, $750 million aggregate principal amount of 3% unsecured senior notes due August 15, 2026 and $1.75 billion aggregate principal amount of 3.25% unsecured senior notes due August 15, 2029 (collectively, the "2019 Notes") for total

proceeds of approximately $3.5 billion, net of discounts and underwriting fees. The net proceeds of the 2019 Notes were used to repay certain of the Company's outstanding debt.

Beginning in July 2019, the Company entered into several interest rate swap and treasury lock transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of the 2019 Notes. In connection with the issuance of the 2019 Notes, the Company terminated all outstanding cash flow hedges. The Company paid a net amount of $25 million to the hedge counterparties upon termination, which was recorded as a loss, net of tax, of $18 million in accumulated other comprehensive income and will be reclassified as interest expense over the life of the 2019 Notes. See Note 13 "Other Comprehensive Income" included in Item 8 of this 10-K for additional information.

Early Extinguishment of Debt
In August 2019, the Company purchased $4.0 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $1.3 billion of its 3.125% senior notes due 2020, $723 million of its floating rate notes due 2020, $328 million of its 4.125% senior notes due 2021, $297 million of 4.125% senior notes due 2021 issued by Aetna, $413 million of 5.45% senior notes due 2021 issued by Coventry Health Care, Inc., a wholly-owned subsidiary of Aetna, and $962 million of its 3.35% senior notes due 2021. In connection with the purchase of such senior notes, the Company paid a premium of $76 million in excess of the aggregate principal amount of the senior notes that were purchased, incurred $8 million in fees and recognized a net gain of $5 million on the write-off of net unamortized deferred financing premiums, for a net loss on early extinguishment of debt of $79 million.

2018 Notes
On March 9, 2018, the Company issued an aggregate of $40.0 billion in principal amount of unsecured floating rate notes and unsecured fixed rate senior notes (collectively the "2018 Notes") for total proceeds of approximately $39.4 billion, net of discounts and underwriting fees. The net proceeds of the 2018 Notes were used to fund a portion of the Aetna Acquisition. The 2018 Notes consisted of the following at the time of issuance:

In millions	
3.125% senior notes due March 2020	$ 2,000
Floating rate notes due March 2020	1,000
3.35% senior notes due March 2021	3,000
Floating rate notes due March 2021	1,000
3.7% senior notes due March 2023	6,000
4.1% senior notes due March 2025	5,000
4.3% senior notes due March 2028	9,000
4.78% senior notes due March 2038	5,000
5.05% senior notes due March 2048	8,000
Total debt principal	$ 40,000

From December 2017 through March 2018, the Company entered into several interest rate swap and treasury lock transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of long-term debt to fund the Aetna Acquisition.

In connection with the issuance of the 2018 Notes, the Company terminated all outstanding cash flow hedges. In connection with the hedge transactions, the Company received a net amount of $446 million from the hedge counterparties upon termination, which was recorded as a gain, net of tax, of $331 million in accumulated other comprehensive income and will be reclassified as a reduction of interest expense over the life of the 2018 Notes. See Note 13 "Other Comprehensive Income" included in Item 8 of this 10-K for additional information.

Term Loan Agreement
On December 15, 2017, in connection with the Aetna Acquisition, the Company entered into a $5.0 billion term loan agreement. The term loan agreement allowed for borrowings at various rates that were dependent, in part, on the Company's debt ratings. In connection with the Aetna Acquisition, the Company borrowed $5.0 billion (a $3.0 billion three-year tranche and a $2.0 billion five-year tranche) under the term loan agreement in November 2018. The

Company terminated the $2.0 billion five-year tranche in December 2018 with the repayment of the borrowing. The Company made principal payments of

$500 million in March 2019, $1.0 billion in May 2019 and $1.5 billion in July 2019 on the three-year tranche, and terminated the three-year tranche and the term loan agreement with the final repayment of the borrowing in July 2019, at which time the Company had repaid all term loans.

Aetna Related Debt
Upon the closing of the Aetna Acquisition, the Company assumed long-term debt with a fair value of $8.1 billion, with stated interest rates ranging from 2.2% to 6.75%.

See Note 8 ‘‘Borrowings and Credit Agreements’’ and Note 12 ‘‘Shareholders’ Equity’’ included in Item 8 of this 10-K for additional information about debt issuances, debt repayments, share repurchases and dividend payments.

Derivative Financial Instruments

The Company uses derivative financial instruments in order to manage interest rate and foreign exchange risk and credit exposure. The Company’s use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps.

Debt Covenants

The Company’s back-up revolving credit facilities, unsecured senior notes and unsecured floating rate notes (see Note 8 ‘‘Borrowings and Credit Agreements’’ included in Item 8 of this 10-K) contain customary restrictive financial and operating covenants. These covenants do not include an acceleration of the Company’s debt maturities in the event of a downgrade in the Company’s credit ratings. The Company does not believe the restrictions contained in these covenants materially affect its financial or operating flexibility. As of December 31, 2019, the Company was in compliance with all of its debt covenants.

Debt Ratings

As of December 31, 2019, the Company’s long-term debt was rated “Baa2” by Moody’s Investors Service, Inc. (“Moody’s) and “BBB” by Standard & Poor’s Financial Services LLC (“S&P”), and its commercial paper program was rated “P-2” by Moody’s and “A-2” by S&P. In December 2017, subsequent to the announcement of the proposed acquisition of Aetna, Moody’s changed the outlook on the Company’s long-term debt to “Under Review” from “Stable.” Similarly, S&P placed the Company’s long-term debt outlook on “Watch Negative” from “Stable.” Upon the issuance of the 2018 Notes on March 9, 2018, S&P lowered its corporate credit rating on the Company’s long-term debt to “BBB” from “BBB+” and changed the outlook from “Watch Negative” to “Stable.” On November 27, 2018, S&P lowered its rating on the long-term debt of Aetna to “BBB” from “A.” On November 28, 2018, upon the completion of the Aetna Acquisition, Moody’s lowered its rating on CVS Health Corporation’s long-term debt to “Baa2” from “Baa1.” Additionally, Moody’s changed the outlook on CVS Health Corporation’s long-term debt to “Negative” from “Under Review” and changed the outlook on the long-term debt of Aetna to “Negative” from “Stable.” In assessing the Company’s credit strength, the Company believes that both Moody’s and S&P considered, among other things, the Company’s capital structure and financial policies as well as its consolidated balance sheet, its historical acquisition activity and other financial information. Although the Company currently believes its long-term debt ratings will remain investment grade, it cannot guarantee the future actions of Moody’s and/or S&P. The Company’s debt ratings have a direct impact on its future borrowing costs, access to capital markets and new store operating lease costs.

Share Repurchase Programs

During the years ended December 31, 2019 and 2018, the Company did not repurchase any shares of common stock. See Note 12 ‘‘Shareholders’ Equity’’ included in Item 8 of this 10-K for information about share repurchases for the year ended December 31, 2017.

Quarterly Cash Dividend

In December 2016, CVS Health’s Board of Directors (the “Board”) authorized an 18% increase in CVS Health’s quarterly common stock cash dividend to $0.50 per share effective in 2017. This increase equated to an annual dividend rate of $2.00 per share. During 2019 and 2018, CVS Health maintained its quarterly dividend of $0.50 per share. CVS Health has paid cash dividends every quarter since becoming a public company and expects to maintain

its quarterly dividend of $0.50 per share throughout 2020. Future dividends will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

Off-Balance Sheet Arrangements

Between 1995 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores and Linens 'n Things, each of which subsequently filed for bankruptcy, and Marshalls. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the former subsidiary's lease obligations for the initial lease term and any extension thereof pursuant to a renewal option provided for in the lease prior to the time of the disposition. When the subsidiaries were disposed of and accounted for as discontinued operations, the Company's guarantees remained in place, although each initial purchaser agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries fail to make the required payments under a store lease, the Company could be required to satisfy those obligations.

As of December 31, 2019, the Company guaranteed 79 such store leases (excluding the lease guarantees related to Linens 'n Things, which have been recorded as a liability on the consolidated balance sheets), with the maximum remaining lease term extending through 2030. Management believes the ultimate disposition of any of the remaining lease guarantees will not have a material adverse effect on the Company's consolidated financial condition or future cash flows. See "Lease Guarantees" in Note 16 "Commitments and Contingencies" included in Item 8 of this 10-K for further information regarding the Company's guarantees of lease obligations.

Contractual Obligations

The following table summarizes certain estimated future obligations by period under the Company's various contractual obligations at December 31, 2019. The table below does not include future payments of claims to health care providers or pharmacies because certain terms of these payments are not determinable at December 31, 2019 (for example, the timing and volume of future services provided under fee-for-service arrangements and future membership levels for capitated arrangements).

	Payments Due by Period				
In millions	**Total**	**2020**	**2021 to 2022**	**2023 to 2024**	**Thereafter**
Operating lease liabilities	$ 27,833	$ 2,699	$ 5,042	$ 4,438	$ 15,654
Finance lease liabilities	1,454	84	161	153	1,056
Contractual lease obligations with Target [1]	2,218	—	—	—	2,218
Lease obligations for discontinued operations	8	4	4	—	—
Long-term debt	68,438	3,754	9,557	11,258	43,869
Interest payments on long-term debt [2]	35,343	2,751	5,076	4,299	23,217
Other long-term liabilities on the consolidated balance sheets [3]					
Future policy benefits [4]	6,127	508	937	809	3,873
Unpaid claims [4]	2,522	705	514	346	957
Policyholders' funds [4] [5]	1,156	553	137	85	381
Other liabilities	1,540	426	801	89	224
Total	$ 146,639	$ 11,484	$ 22,229	$ 21,477	$ 91,449

(1) The Company leases pharmacy and clinic space from Target Corporation ("Target"). See Note 6 "Leases" included in Item 8 of this 10-K for additional information regarding the lease arrangements with Target. Amounts related to such operating and finance leases are reflected within the operating lease liabilities and finance lease liabilities in the table above. Pharmacy lease amounts due in excess of the remaining estimated economic life of the buildings are reflected in the table above assuming equivalent stores continue to operate through the term of the arrangements.

(2) Interest payments on long-term debt are calculated using outstanding balances and interest rates in effect on December 31, 2019.

(3) Payments of other long-term liabilities exclude Separate Accounts liabilities of approximately $4.5 billion because these liabilities are supported by assets that are legally segregated and are not subject to claims that arise out of the Company's business.

(4) Total payments of future policy benefits, unpaid claims and policyholders' funds include $807 million, $2.5 billion and $291 million, respectively, of reserves for contracts subject to reinsurance. The Company expects the assuming reinsurance carrier to fund these obligations and has reflected these amounts as reinsurance recoverable assets on the consolidated balance sheets.

(5) Customer funds associated with group life and health contracts of approximately $2.4 billion have been excluded from the table above because such funds may be used primarily at the customer's discretion to offset future premiums and/or for refunds, and the timing of the related cash flows cannot be determined. Additionally, net unrealized capital gains on debt securities supporting experience-rated products of $83 million, before tax, have been excluded from the table above.

Restrictions on Certain Payments

In addition to general state law restrictions on payments of dividends and other distributions to stockholders applicable to all corporations, health maintenance organizations ("HMOs") and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity (referred to as surplus) and restrict the amount of dividends and other distributions that may be paid to their equity holders. These regulations are not directly applicable to CVS Health as a holding company, since CVS Health is not an HMO or an insurance company. In addition, in connection with the Aetna Acquisition, the Company made certain undertakings that require prior regulatory approval of dividends by certain of its HMOs and insurance companies. The additional regulations and undertakings applicable to the Company's HMO and insurance company subsidiaries are not expected to affect the Company's ability to service the Company's debt, meet other financing obligations or pay dividends, or the ability of any of the Company's subsidiaries to service their debt or other financing obligations. Under applicable regulatory requirements and undertakings, at December 31, 2019, the maximum amount of dividends that may be paid by the Company's insurance and HMO subsidiaries without prior approval by regulatory authorities was $366 million in the aggregate.

The Company maintains capital levels in its operating subsidiaries at or above targeted and/or required capital levels and dividends amounts in excess of these levels to meet liquidity requirements, including the payment of interest on debt and stockholder dividends. In addition, at the Company's discretion, it uses these funds for other purposes such as funding share and debt repurchase programs, investments in new businesses and other purposes considered advisable.

At December 31, 2019 and 2018, the Company held investments of $537 million and $531 million, respectively, that are not accounted for as Separate Accounts assets but are legally segregated and are not subject to claims that arise out of the Company's business. See Note 3 ''Investments'' included in Item 8 of this 10-K for additional information on investments related to the 2012 conversion of an existing group annuity contract from a participating to a non-participating contract.

Solvency Regulation

The National Association of Insurance Commissioners (the "NAIC") utilizes risk-based capital ("RBC") standards for insurance companies that are designed to identify weakly-capitalized companies by comparing each company's adjusted surplus to its required surplus (the "RBC Ratio"). The RBC Ratio is designed to reflect the risk profile of insurance companies. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring an insurer to submit a comprehensive financial plan for increasing its RBC to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2019, the RBC Ratio of each of the Company's primary insurance subsidiaries was above the level that would require regulatory action. The RBC framework described above for insurers has been extended by the NAIC to health organizations, including HMOs. Although not all states had adopted these rules at December 31, 2019, at that date, each of the Company's active HMOs had a surplus that exceeded either the applicable state net worth requirements or, where adopted, the levels that would require regulatory action under the NAIC's RBC rules. External rating agencies use their own capital models and/or RBC standards when they determine a company's rating.

Critical Accounting Policies

The Company prepares the consolidated financial statements in conformity with generally accepted accounting principles, which require management to make certain estimates and apply judgment. Estimates and judgments are based on historical experience, current trends and other factors that management believes to be important at the time the consolidated financial statements are prepared. On a regular basis, the Company reviews its accounting policies and how they are applied and disclosed in the consolidated financial statements. While the Company believes the historical experience, current trends and other factors considered by management support the preparation of the consolidated financial statements in conformity with generally accepted accounting principles, actual results could differ from estimates, and such differences could be material.

Significant accounting policies are discussed in Note 1 ‘‘Significant Accounting Policies’’ included in Item 8 of this 10-K. Management believes the following accounting policies include a higher degree of judgment and/or complexity and, thus, are considered to be critical accounting policies. The Company has discussed the development and selection of these critical accounting policies with the Audit Committee of the Board (the “Audit Committee”), and the Audit Committee has reviewed the disclosures relating to them.

Revenue Recognition

Pharmacy Services Segment
The Pharmacy Services segment sells prescription drugs directly through its mail service dispensing pharmacies and indirectly through the Company’s retail pharmacy network. The Company’s pharmacy benefit arrangements are accounted for in a manner consistent with a master supply arrangement as there are no contractual minimum volumes and each prescription is considered a separate purchasing decision and distinct performance obligation transferred at a point in time. PBM services performed in connection with each prescription claim are considered part of a single performance obligation which culminates in the dispensing of prescription drugs.

The Company recognizes revenue using the gross method at the contract price negotiated with its clients when the Company has concluded it controls the prescription drug before it is transferred to the client plan members. The Company controls prescriptions dispensed indirectly through its retail pharmacy network because it has separate contractual arrangements with those pharmacies, has discretion in setting the price for the transaction and assumes primary responsibility for fulfilling the promise to provide prescription drugs to its client plan members while also performing the related PBM services.

Revenues include (i) the portion of the price the client pays directly to the Company, net of any discounts earned on brand name drugs or other discounts and refunds paid back to the client (see “Drug Discounts” and “Guarantees” below), (ii) the price paid to the Company by client plan members for mail order prescriptions and the price paid to retail network pharmacies by client plan members for retail prescriptions (“retail co-payments”), and (iii) claims based administrative fees for retail pharmacy network contracts. Sales taxes are not included in revenues.

The Company recognizes revenue when control of the prescription drugs is transferred to customers, in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those prescription drugs. The Company has established the following revenue recognition policies for the Pharmacy Services segment:

- Revenues generated from prescription drugs sold by mail service dispensing pharmacies are recognized when the prescription drug is delivered to the client plan member. At the time of delivery, the Company has performed substantially all of its performance obligations under its client contracts and does not experience a significant level of returns or reshipments.
- Revenues generated from prescription drugs sold by third party pharmacies in the Company’s retail pharmacy network and associated administrative fees are recognized at the Company’s point-of-sale, which is when the claim is adjudicated by the Company’s online claims processing system and the Company has transferred control of the prescription drug and performed all of its performance obligations.

For contracts under which the Company acts as an agent or does not control the prescription drugs prior to transfer to the client plan member, revenue is recognized using the net method.

<u>Drug Discounts</u>

The Company records revenue net of manufacturers' rebates earned by its clients based on their plan members' utilization of brand-name formulary drugs. The Company estimates these rebates at period-end based on actual and estimated claims data and its estimates of the manufacturers' rebates earned by its clients. The estimates are based on the best available data at period-end

and recent history for the various factors that can affect the amount of rebates due to the client. The Company adjusts its rebates payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. Any cumulative effect of these adjustments is recorded against revenues at the time it is identified. Adjustments generally result from contract changes with clients or manufacturers that have retroactive rebate adjustments, differences between the estimated and actual product mix subject to rebates, or whether the brand name drug was included in the applicable formulary. The effect of adjustments between estimated and actual manufacturers' rebate amounts has not been material to the Company's operating results or financial condition.

Guarantees

The Company also adjusts revenues for refunds owed to clients resulting from pricing guarantees and performance against defined service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Retail/LTC Segment

Retail Pharmacy

The Company's retail drugstores recognize revenue at the time the customer takes possession of the merchandise. For pharmacy sales, each prescription claim is its own arrangement with the customer and is a performance obligation, separate and distinct from other prescription claims under other retail network arrangements. Revenues are adjusted for refunds owed to third party payers resulting from pricing guarantees and performance against defined value-based service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Revenue from Company gift cards purchased by customers is deferred as a contract liability until goods or services are transferred. Any amounts not expected to be redeemed by customers (i.e., breakage) are recognized based on historical redemption patterns.

Customer returns are not material to the Company's operating results or financial condition. Sales taxes are not included in revenues.

Loyalty and Other Programs

The Company's customer loyalty program, ExtraCare®, consists of two components, ExtraSavings™ and ExtraBucks® Rewards. ExtraSavings are coupons that are recorded as a reduction of revenue when redeemed as the Company concluded that they do not represent a promise to the customer to deliver additional goods or services at the time of issuance because they are not tied to a specific transaction or spending level.

ExtraBucks Rewards are accumulated by customers based on their historical spending levels. Thus, the Company has determined that there is an additional performance obligation to those customers at the time of the initial transaction. The Company allocates the transaction price to the initial transaction and the ExtraBucks Rewards transaction based upon the relative standalone selling price, which considers historical redemption patterns for the rewards. Revenue allocated to ExtraBucks Rewards is recognized as those rewards are redeemed. At the end of each period, unredeemed ExtraBucks Rewards are reflected as a contract liability.

The Company also offers a subscription-based membership program, CarePass®, under which members are entitled to a suite of benefits delivered over the course of the subscription period, as well as a promotional reward that can be redeemed for future goods and services. Subscriptions are paid for on a monthly or annual basis at the time of or in advance of the Company delivering the goods and services. Revenue from these arrangements is recognized as the performance obligations are satisfied.

Long-term Care

Revenue is recognized when control of the promised goods or services is transferred to customers in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those goods or services. Each prescription claim represents a separate performance obligation of the Company, separate and distinct from other prescription claims under customer arrangements. A significant portion of Long-term Care revenue from sales of pharmaceutical and medical products is reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. The Company monitors its revenues and receivables from these reimbursement sources, as well as long-term care facilities and other third party insurance payors, and reduces revenue at the revenue recognition date to properly account for the variable consideration due to anticipated

differences between billed and reimbursed amounts. Accordingly, the total revenues and receivables reported in the Company's consolidated financial statements are recorded at the amount expected to be ultimately received from these payors.

Patient co-payments associated with Medicare Part D, certain state Medicaid programs, Medicare Part B and certain third party payors typically are not collected at the time products are delivered or services are rendered, but are billed to the individuals as part of normal billing procedures and subject to normal accounts receivable collections procedures.

Walk-In Medical Clinics

For services provided by the Company's walk-in medical clinics, revenue recognition occurs for completed services provided to patients, with adjustments taken for third party payor contractual obligations and patient direct bill historical collection rates.

Health Care Benefits Segment

Health Care Benefits revenue is principally derived from insurance premiums and fees billed to customers. Revenue is recognized based on customer billings, which reflect contracted rates per employee and the number of covered employees recorded in the Company's records at the time the billings are prepared. Billings are generally sent monthly for coverage during the following month.

The Company's billings may be subsequently adjusted to reflect enrollment changes due to member terminations or other factors. These adjustments are known as retroactivity adjustments. In each period, the Company estimates the amount of future retroactivity and adjusts the recorded revenue accordingly. As information regarding actual retroactivity amounts becomes known, the Company refines its estimates and records any required adjustments to revenues in the period in which they arise. A significant difference in the actual level of retroactivity compared to estimated levels would have a significant effect on the Company's operating results.

Premium Revenue

Premiums are recognized as revenue in the month in which the enrollee is entitled to receive health care services. Premiums are reported net of an allowance for estimated terminations and uncollectible amounts. Additionally, premium revenue subject to the ACA's minimum medical loss ratio ("MLR") rebate requirements is recorded net of the estimated minimum MLR rebates for the current calendar year. Premiums related to unexpired contractual coverage periods (unearned premiums) are reported as other insurance liabilities on the consolidated balance sheets and recognized as revenue when earned.

Some of the Company's contracts allow for premiums to be adjusted to reflect actual experience or the relative health status of Insured members. Such adjustments are reasonably estimable at the outset of the contract, and adjustments to those estimates are made based on actual experience of the customer emerging under the contract and the terms of the underlying contract.

Services Revenue

Services revenue relates to contracts that can include various combinations of services or series of services which generally are capable of being distinct and accounted for as separate performance obligations. The Health Care Benefits segment's services revenue primarily consists of the following components:

- ASC fees are received in exchange for performing certain claim processing and member services for ASC members. ASC fee revenue is recognized over the period the service is provided. Some of the Company's administrative services contracts include guarantees with respect to certain functions, such as customer service response time, claim processing accuracy and claim processing turnaround time, as well as certain guarantees that a plan sponsor's benefit claim experience will fall within a certain range. With any of these guarantees, the Company is financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk typically is limited to a percentage of the fees otherwise payable to the Company by the customer involved. Each period the Company estimates its obligations under the terms of these guarantees and records its estimate as an offset to services revenues.
- Workers' compensation administrative services consist of fee-based managed care services. Workers' compensation administrative services revenue is recognized once the service is provided.

Accounting for Medicare Part D

Revenues include insurance premiums earned by the Company's PDPs, which are determined based on the PDP's annual bid and related contractual arrangements with CMS. The insurance premiums include a beneficiary premium, which is the responsibility of the PDP member, and can be subsidized by CMS in the case of low-income members, and a direct premium paid by CMS. Premiums collected in advance are initially recorded within other insurance liabilities and are then recognized ratably as revenue over the period in which members are entitled to receive benefits.

Revenues also include a risk-sharing feature of the Medicare Part D program design referred to as the risk corridor. The Company estimates variable consideration in the form of amounts payable to, or receivable from, CMS under the risk corridor, and adjusts revenue based on calculations of additional subsidies to be received from or owed to CMS at the end of the reporting year.

In addition to Medicare Part D premiums, the Company receives additional payments each month from CMS related to catastrophic reinsurance, low-income cost sharing subsidies and coverage gap benefits. If the subsidies received differ from the amounts earned from actual prescriptions transferred, the difference is recorded in either accounts receivable, net or accrued expenses.

Other-Than-Temporary Impairments of Debt Securities

The Company regularly reviews its debt securities to determine whether a decline in fair value below the cost basis or carrying value is other-than-temporary. If a decline in the fair value of a debt security is considered other-than-temporary, the cost basis or carrying value of the debt security is written down. The write-down is then bifurcated into its credit and non-credit related components. The amount of the credit-related component is included in the Company's net income (loss), and the amount of the non-credit related component is included in other comprehensive income (loss), unless the Company intends to sell the debt security or it is more likely than not that the Company will be required to sell the debt security prior to its anticipated recovery of the debt security's amortized cost basis. The Company analyzes all facts and circumstances believed to be relevant for each investment when performing this analysis, in accordance with applicable accounting guidance.

Among the factors considered in evaluating whether a decline in fair value is other-than-temporary are whether the decline results from a change in the quality of the debt security itself, whether the decline results from a downward movement in the market as a whole, and the prospects for realizing the carrying value of the debt security based on the investment's current and short-term prospects for recovery. For unrealized losses determined to be the result of market conditions (for example, increasing interest rates and volatility due to conditions in the overall market) or industry-related events, the Company determines whether it intends to sell the debt security or if it is more likely than not that the Company will be required to sell the debt security prior to its anticipated recovery of the debt security's amortized cost basis. If either case is true, the Company recognizes an other-than-temporary impairment, and the cost basis/carrying amount of the debt security is written down to fair value.

The risks inherent in assessing the impairment of a debt security include the risk that market factors may differ from projections and the risk that the facts and circumstances factored into the Company's assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods are among the factors that may result in a current period decision to sell debt securities that were not impaired in prior reporting periods.

Vendor Allowances and Purchase Discounts

Pharmacy Services Segment
The Pharmacy Services segment receives purchase discounts on products purchased. Contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for the Pharmacy Services segment to receive purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These rebates are recognized when prescriptions are dispensed and are generally calculated and billed to manufacturers within 30 days of the end of each completed quarter. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material to the Company's operating results or financial condition. The Company accounts for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. The Pharmacy Services segment also receives additional discounts under its wholesaler contracts if it exceeds contractually defined purchase volumes. In addition, the Pharmacy Services segment receives fees from pharmaceutical manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of cost of products sold.

Retail/LTC Segment
Vendor allowances received by the Retail/LTC segment reduce the carrying cost of inventory and are recognized in cost of products sold when the related inventory is sold, unless they are specifically identified as a reimbursement of

incremental costs for promotional programs and/or other services provided. Amounts that are directly linked to advertising commitments are recognized as a reduction of advertising expense (included in operating expenses) when the related advertising commitment is

satisfied. Any such allowances received in excess of the actual cost incurred also reduce the carrying cost of inventory. The total value of any upfront payments received from vendors that are linked to purchase commitments is initially deferred. The deferred amounts are then amortized to reduce cost of products sold over the life of the contract based upon purchase volume. The total value of any upfront payments received from vendors that are not linked to purchase commitments is also initially deferred. The deferred amounts are then amortized to reduce cost of products sold on a straight-line basis over the life of the related contract.

There have not been any material changes in the way the Company accounts for vendor allowances or purchase discounts during the past three years.

Inventory

Inventories are valued at the lower of cost or net realizable value using the weighted average cost method.

The value of ending inventory is reduced for estimated inventory losses that have occurred during the interim period between physical inventory counts. Physical inventory counts are taken on a regular basis in each retail store and LTC pharmacy, and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the consolidated financial statements are properly stated. The Company's accounting for inventory contains uncertainty since management must use judgment to estimate the inventory losses that have occurred during the interim period between physical inventory counts. When estimating these losses, a number of factors are considered which include historical physical inventory results on a location-by-location basis and current physical inventory loss trends.

The total reserve for estimated inventory losses covered by this critical accounting policy was $401 million as of December 31, 2019. Although management believes there is sufficient current and historical information available to record reasonable estimates for estimated inventory losses, it is possible that actual results could differ. In order to help investors assess the aggregate risk, if any, associated with the inventory-related uncertainties discussed above, a ten percent (10%) pre-tax change in estimated inventory losses, which is a reasonably likely change, would increase or decrease the total reserve for estimated inventory losses by approximately $40 million as of December 31, 2019.

Although management believes that the estimates discussed above are reasonable and the related calculations conform to generally accepted accounting principles, actual results could differ from such estimates, and such differences could be material.

Right-of-Use Assets and Lease Liabilities

The Company determines if an arrangement contains a lease at the inception of a contract. Right-of-use assets represent the Company's right to use an underlying asset for the lease term and lease liabilities represent the Company's obligation to make lease payments arising from the lease. Right-of-use assets and lease liabilities are recognized at the commencement date of the lease, renewal date of the lease or significant remodeling of the lease space based on the present value of the remaining future minimum lease payments. As the interest rate implicit in the Company's leases is not readily determinable, the Company utilizes its incremental borrowing rate, determined by class of underlying asset, to discount the lease payments. The operating lease right-of-use assets also include lease payments made before commencement and are reduced by lease incentives.

The Company's real estate leases typically contain options that permit renewals for additional periods of up to five years each. For real estate leases, the options to extend are not considered reasonably certain at lease commencement because the Company reevaluates each lease on a regular basis to consider the economic and strategic incentives of exercising the renewal options and regularly opens or closes stores to align with its operating strategy. Generally, the renewal option periods are not included within the lease term and the associated payments are not included in the measurement of the right-of-use asset and lease liability. Similarly, renewal options are not included in the lease term for non-real estate leases because they are not considered reasonably certain of being exercised at lease commencement. Leases with an initial term of 12 months or less are not recorded on the balance sheets, and lease expense is recognized on a straight-line basis over the term of the short-term lease.

For real estate leases, the Company accounts for lease components and nonlease components as a single lease component. Certain real estate leases require additional payments based on sales volume, as well as reimbursement for real estate taxes, common area maintenance and insurance, which are expensed as incurred as variable lease costs. Other real estate leases contain one fixed lease payment that includes real estate taxes, common area

maintenance and insurance. These fixed payments are considered part of the lease payment and included in the right-of-use assets and lease liabilities.

Long-Lived Asset Impairment

Recoverability of Definite-Lived Assets
The Company evaluates the recoverability of long-lived assets, excluding goodwill and indefinite-lived intangible assets, which are tested for impairment using separate tests described below, whenever events or changes in circumstances indicate that the carrying value of such an asset may not be recoverable. The Company groups and evaluates these long-lived assets for impairment at the lowest level at which individual cash flows can be identified. If indicators of impairment are present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted and without interest charges). If the estimated future cash flows used in this analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group's estimated future cash flows (discounted and with interest charges). If required, an impairment loss is recorded for the portion of the asset group's carrying value that exceeds the asset group's estimated future cash flows (discounted and with interest charges).

The long-lived asset impairment loss calculation contains uncertainty since management must use judgment to estimate each asset group's future sales, profitability and cash flows. When preparing these estimates, the Company considers historical results and current operating trends and consolidated sales, profitability and cash flow results and forecasts. These estimates can be affected by a number of factors including general economic and regulatory conditions, efforts of third party organizations to reduce their prescription drug costs and/or increased member co-payments, the continued efforts of competitors to gain market share and consumer spending patterns.

During the year ended December 31, 2019, the Company recorded store rationalization charges of $231 million, primarily related to operating lease right-of-use asset impairment charges. During the year ended December 31, 2018, the Company recognized a $43 million long-lived asset impairment charge, primarily related to the impairment of property and equipment. There were no material impairment charges recognized on long-lived assets in the year ended December 31, 2017.

Recoverability of Goodwill
Goodwill represents the excess of amounts paid for acquisitions over the fair value of the net identifiable assets acquired. Goodwill is subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable. Goodwill is tested for impairment on a reporting unit basis. The impairment test is performed by comparing the reporting unit's fair value with its net book value (or carrying amount), including goodwill. The fair value of the reporting units is estimated using a combination of a discounted cash flow method and a market multiple method. If the net book value (carrying amount) of the reporting unit exceeds its fair value, the reporting unit's goodwill is considered to be impaired, and an impairment is recognized in an amount equal to the excess.

The determination of the fair value of the reporting units requires the Company to make significant assumptions and estimates. These assumptions and estimates primarily include the selection of appropriate peer group companies; control premiums and valuation multiples appropriate for acquisitions in the industries in which the Company competes; discount rates; terminal growth rates; and forecasts of revenue, operating income, depreciation and amortization, income taxes, capital expenditures and future working capital requirements. When determining these assumptions and preparing these estimates, the Company considers each reporting unit's historical results and current operating trends; consolidated revenues, profitability and cash flow results and forecasts; and industry trends. The Company's estimates can be affected by a number of factors, including general economic and regulatory conditions; the risk-free interest rate environment; the Company's market capitalization; efforts of customers and payers to reduce costs, including their prescription drug costs, and/or increase member co-payments; the continued efforts of competitors to gain market share and consumer spending patterns.

2019 Goodwill Impairment Test
During the third quarter of 2019, the Company performed its required annual impairment test of goodwill. The results of this impairment test indicated that there was no impairment of goodwill as of the testing date. The goodwill impairment test resulted in the fair values of all of the Company's reporting units exceeding their carrying values by significant margins, with the exception of the Commercial Business and LTC reporting units, which exceeded their carrying values by approximately 4% and 9%, respectively.

As of the Aetna Acquisition Date, the Company added the Health Care Benefits segment which included the Commercial Business reporting unit. The transaction was accounted for using the acquisition method of accounting

which requires, among other things, the assets acquired and liabilities assumed to be recognized at their fair values at the date of acquisition. As a result, at the time of the acquisition the fair value of the Commercial Business reporting unit was equal to its carrying value. Given the close proximity of the Aetna Acquisition Date to the 2019 annual impairment test of goodwill, as expected, the fair

value of the Commercial Business reporting unit remained relatively in line with the carrying value of the reporting unit. In addition, this fair value estimate is sensitive to significant assumptions including changes in the revenue growth rate, operating income and the discount rate.

Although the Company believes the financial projections used to determine the fair value of the LTC reporting unit in the third quarter of 2019 were reasonable and achievable, the LTC reporting unit may continue to face challenges that may affect the Company's ability to grow the LTC reporting unit's business at the rate estimated when such goodwill impairment test was performed. These challenges and some of the key assumptions included in the Company's financial projections to determine the estimated fair value of the LTC reporting unit include client retention rates; occupancy rates in skilled nursing facilities; the financial health of skilled nursing facility customers; facility reimbursement pressures; the Company's ability to execute its senior living initiative; the Company's ability to make acquisitions and integrate those businesses into its LTC operations in an orderly manner; and the Company's ability to extract cost savings from labor productivity and other initiatives. The fair value of the LTC reporting unit also is dependent on market multiples of peer group companies and the risk-free interest rate environment, which impacts the discount rate used in the discounted cash flow valuation method. If the Company does not achieve its forecasts, it is reasonably possible in the near term that the goodwill of the LTC reporting unit could be deemed to be impaired by a material amount. As of December 31, 2019, the remaining goodwill balance in the LTC reporting unit was $431 million.

2018 Goodwill Impairment Tests

As discussed in Note 5 ''Goodwill and Other Intangibles'' included in Item 8 of this 10-K, during 2018, the LTC reporting unit continued to experience industry-wide challenges that impacted management's ability to grow the business at the rate that was originally estimated when the Company acquired Omnicare and when the 2017 annual goodwill impairment test was performed. Those challenges included lower client retention rates, lower occupancy rates in skilled nursing facilities, the deteriorating financial health of numerous skilled nursing facility customers which resulted in a number of customer bankruptcies in 2018, and continued facility reimbursement pressures. In June 2018, LTC management submitted its initial budget for 2019 and updated the 2018 annual forecast which showed a deterioration in the projected financial results for the remainder of 2018 and in 2019, which also caused management to update its long-term forecast beyond 2019. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be impaired and, accordingly, management performed an interim goodwill impairment test as of June 30, 2018. The results of that interim impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in a $3.9 billion pre-tax goodwill impairment charge in the second quarter of 2018.

During the third quarter of 2018, the Company performed its required annual impairment tests of goodwill and concluded there was no impairment of goodwill. The goodwill impairment tests showed that the fair values of the Pharmacy Services and Retail Pharmacy reporting units exceeded their carrying values by significant margins and the fair value of the LTC reporting unit exceeded its carrying value by approximately 2%.

During the fourth quarter of 2018, the LTC reporting unit missed its forecast primarily due to operational issues and customer liquidity issues, including one significant customer bankruptcy. Additionally, LTC management submitted an updated final budget for 2019 which showed significant additional deterioration in the projected financial results for 2019 compared to the analyses performed in the second and third quarters of 2018 primarily due to continued industry and operational challenges, which also caused management to make further updates to its long-term forecast beyond 2019. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be further impaired and, accordingly, management performed an interim goodwill impairment test during the fourth quarter of 2018. The results of that interim impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in an additional $2.2 billion pre-tax goodwill impairment charge in the fourth quarter of 2018.

In 2018, the fair value of the LTC reporting unit was determined using a combination of a discounted cash flow method and a market multiple method. In addition to the lower financial projections, changes in risk-free interest rates and lower market multiples of peer group companies also contributed to the amount of the 2018 goodwill impairment charges.

2017 Goodwill Impairment Tests

The Company recorded $181 million in goodwill impairment charges in 2017 related to the RxCrossroads reporting unit. During the third quarter of 2017, the Company performed its required annual impairment test of goodwill. The goodwill impairment test showed that the fair values of the Pharmacy Services and Retail Pharmacy reporting units

exceeded their carrying values by significant margins and the fair values of the LTC and RxCrossroads reporting units exceeded their carrying values by approximately 1% and 6%, respectively. On January 2, 2018, the Company sold its RxCrossroads reporting unit to McKesson Corporation for $725 million.

Recoverability of Indefinite-Lived Intangible Assets
Indefinite-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that their carrying value may not be recoverable. Indefinite-lived intangible assets are tested by comparing the estimated fair value of the asset to its carrying value. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized, and the asset is written down to its estimated fair value.

The indefinite-lived intangible asset impairment loss calculation contains uncertainty since management must use judgment to estimate fair value based on the assumption that, in lieu of ownership of an intangible asset, the Company would be willing to pay a royalty in order to utilize the benefits of the asset. Fair value is estimated by discounting the hypothetical royalty payments to their present value over the estimated economic life of the asset. These estimates can be affected by a number of factors including general economic conditions, availability of market information and the profitability of the Company. There were no impairment losses recognized on indefinite-lived intangible assets in any of the years ended December 31, 2019, 2018 or 2017.

Health Care Costs Payable

At December 31, 2019 and 2018, 73% and 67% respectively, of health care costs payable are estimates of the ultimate cost of (i) services rendered to the Company's Insured members but not yet reported to the Company and (ii) claims which have been reported to the Company but not yet paid (collectively, "IBNR"). Health care costs payable also include an estimate of the cost of services that will continue to be rendered after the financial statement date if the Company is obligated to pay for such services in accordance with contractual or regulatory requirements. The remainder of health care costs payable is primarily comprised of pharmacy and capitation payables, other amounts due to providers pursuant to risk sharing agreements and accruals for state assessments. The Company develops its estimate of IBNR using actuarial principles and assumptions that consider numerous factors. See Note 1 "Significant Accounting Policies" included in Item 8 of this 10-K for additional information on the Company's reserving methodology.

During 2019, the Company observed an increase in completion factors relative to those assumed at the prior year end. After considering the claims paid in 2019 with dates of service prior to the fourth quarter of the previous year, the Company observed assumed incurred claim weighted average completion factors that were 27 basis points higher than previously estimated, resulting in a decrease of $240 million in 2019, in health care costs payable that related to the prior year. The Company has considered the pattern of changes in its completion factors when determining the completion factors used in its estimates of IBNR as of December 31, 2019. However, based on historical claim experience, it is reasonably possible that the Company's estimated weighted average completion factors may vary by plus or minus 19 basis points from the Company's assumed rates, which could impact health care costs payable by approximately plus or minus $227 million pretax.

Also during 2019, the Company observed that health care costs for claims with claim incurred dates of three months or less before the financial statement date were lower than previously estimated. Specifically, after considering the claims paid in 2019 with claim incurred dates for the fourth quarter of the previous year, the Company observed health care costs that were approximately 3.2% lower than previously estimated during the fourth quarter of 2018, resulting in a reduction of $284 million in 2019 in health care costs payable that related to prior year.

Management considers historical health care cost trend rates together with its knowledge of recent events that may impact current trends when developing estimates of current health care cost trend rates. When establishing reserves as of December 31, 2019, the Company increased its assumed health care cost trend rates for the most recent three months by 3.4% from health care cost trend rates recently observed. However, based on historical claim experience, it is reasonably possible that the Company's estimated health care cost trend rates may vary by plus or minus 3.5% from the assumed rates, which could impact health care costs payable by plus or minus $349 million pretax.

Income Taxes

The Company accounts for income taxes using the asset and liability method. Deferred tax assets and liabilities are established for any temporary differences between financial and tax reporting bases and are adjusted as needed to reflect changes in the enacted tax rates expected to be in effect when the temporary differences reverse. Such adjustments are recorded in the period in which changes in tax laws are enacted, regardless of when they are effective. Deferred tax assets are reduced, if necessary, by a valuation allowance to the extent future realization of those losses, deductions or other tax benefits is sufficiently uncertain.

Significant judgment is required in determining the provision for income taxes and the related taxes payable and deferred tax assets and liabilities since, in the ordinary course of business, there are transactions and calculations where the ultimate tax outcome is uncertain. Additionally, the Company's tax returns are subject to audit by various domestic and foreign tax

authorities that could result in material adjustments based on differing interpretations of the tax laws. Although management believes that its estimates are reasonable and are based on the best available information at the time the provision is prepared, actual results could differ from these estimates resulting in a final tax outcome that may be materially different from that which is reflected in the consolidated financial statements.

The tax benefit from an uncertain tax position is recognized only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The tax benefits recognized in the consolidated financial statements from such positions are then measured based on the largest benefit that has a greater than 50% likelihood of being realized upon settlement with the related tax authority. Interest and/or penalties related to uncertain tax positions are recognized in the income tax provision. Significant judgment is required in determining uncertain tax positions. The Company has established accruals for uncertain tax positions using its judgment and adjusts these accruals, as warranted, due to changing facts and circumstances.

New Accounting Pronouncements

See Note 1 ‘‘Significant Accounting Policies’’ included in Item 8 of this 10-K for a description of new accounting pronouncements applicable to the Company.

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Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

The Company's earnings and financial condition are exposed to interest rate risk, credit quality risk, market valuation risk, foreign currency risk, commodity risk and operational risk.

Evaluation of Interest Rate and Credit Quality Risk

The Company manages interest rate risk by seeking to maintain a tight match between the durations of assets and liabilities when appropriate. The Company manages credit quality risk by seeking to maintain high average credit quality ratings and diversified sector exposure within its debt securities portfolio. In connection with its investment and risk management objectives, the Company also uses derivative financial instruments whose market value is at least partially determined by, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets or credit ratings/spreads. The Company's use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps. These instruments, viewed separately, subject the Company to varying degrees of interest rate, equity price and credit risk. However, when used for hedging, the Company expects these instruments to reduce overall risk.

Investments

The Company's investment portfolio supported the following products at December 31, 2019 and 2018:

In millions	**2019**	**2018**
Experience-rated products	$ 1,100	$ 1,063
Remaining products	18,587	17,191
Total investments	$ 19,687	$ 18,254

Investment risks associated with experience-rated products generally do not impact the Company's operating results. The risks associated with investments supporting experience-rated pension and annuity products in the large case pensions business in the Company's Corporate/Other segment are assumed by the contract holders and not by the Company (subject to, among other things, certain minimum guarantees). Assets supporting experience-rated products may be subject to contract holder or participant withdrawals.

The debt securities in the Company's investment portfolio had an average credit quality rating of A at both December 31, 2019 and 2018 with approximately $4.4 billion and $3.9 billion rated AAA at December 31, 2019 and 2018, respectively. The debt securities that were rated below investment grade (that is, having a credit quality rating below BBB-/Baa3) were $1.2 billion and $1.1 billion at December 31, 2019 and 2018, respectively (of which 4% and 6% at December 31, 2019 and 2018, respectively, supported experience-rated products).

At December 31, 2019 and 2018, the Company held $333 million and $373 million, respectively, of municipal debt securities that were guaranteed by third parties, representing 2% of total investments at both December 31, 2019 and 2018. These securities had an average credit quality rating of AA and AA- at December 31, 2019 and 2018, respectively, with the guarantee. These securities had an average credit quality rating of A+ and A- at December 31, 2019 and 2018, respectively, without the guarantee. The Company does not have any significant concentration of investments with third party guarantors (either direct or indirect).

The Company generally classifies debt securities as available for sale, and carries them at fair value on the consolidated balance sheets. At both December 31, 2019 and 2018, less than 1% of debt securities were valued using inputs that reflect the Company's assumptions (categorized as Level 3 inputs in accordance with accounting principles generally accepted in the United States of America). See Note 4 "Fair Value" included in Item 8 of this 10-K, for additional information on the methodologies and key assumptions used to determine the fair value of investments. For additional information related to investments, see Note 3 "Investments" included in Item 8 of this 10-K.

The Company regularly reviews debt securities in its portfolio to determine whether a decline in fair value below the cost basis or carrying value is other-than-temporary. When a debt security is in an unrealized capital loss position, the Company monitors the duration and severity of the loss to determine if sufficient market recovery can occur within a reasonable period of time. If a decline in fair value is considered other-than-temporary, the cost basis or carrying

value of the debt security is written down. The write down is then bifurcated into its credit and non-credit related components. The amount of the credit-related component

is included in net income, and the amount of the non-credit related component is included in other comprehensive income (loss), unless the Company intends to sell the debt security or it is more likely than not that the Company will be required to sell the debt security prior to its anticipated recovery of the debt security's amortized cost basis. Accounting for other-than-temporary impairment ("OTTI") of debt securities is considered a critical accounting policy. See "Critical Accounting Policies - Other-Than-Temporary Impairment of Debt Securities" in the MD&A included in Item 7 of this 10-K for additional information.

Evaluation of Market Valuation Risks

The Company regularly evaluates its risk from market-sensitive instruments by examining, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets and/or credit ratings/spreads. The Company also regularly evaluates the appropriateness of investments relative to management-approved investment guidelines (and operates within those guidelines) and the business objectives of its portfolios.

On a quarterly basis, the Company reviews the impact of hypothetical net losses in its investment portfolio on the Company's consolidated near-term financial condition, operating results and cash flows assuming the occurrence of certain reasonably possible changes in near-term market rates and prices. Interest rate changes (whether resulting from changes in treasury yields or credit spreads or other factors) represent the most material risk exposure category for the Company. The Company has estimated the impact on the fair value of market sensitive instruments based on the net present value of cash flows using a representative set of likely future interest rate scenarios. The assumptions used were as follows: an immediate increase of 100 basis points in interest rates (which the Company believes represents a moderately adverse scenario and is approximately equal to the historical annual volatility of interest rate movements for intermediate-term available-for-sale debt securities) and an immediate decrease of 15% in prices for domestic equity securities.

Assuming an immediate increase of 100 basis points in interest rates and an immediate decrease of 15% in the prices for domestic equity securities, the theoretical decline in the fair values of market sensitive instruments at December 31, 2019 is as follows:

- The fair value of long-term debt would decline by approximately $4.5 billion ($5.7 billion pretax). Changes in the fair value of long-term debt do not impact the Company's operating results or financial condition.

- The theoretical reduction in the fair value of investment securities partially offset by the theoretical reduction in the fair value of interest rate sensitive liabilities would result in a net decline in fair value of approximately $420 million ($530 million pretax) related to continuing non-experience-rated products. Reductions in the fair value of investment securities would be reflected as an unrealized loss in equity, as the Company classifies these securities as available for sale. The Company does not record liabilities at fair value.

Based on overall exposure to interest rate risk and equity price risk, the Company believes that these changes in market rates and prices would not materially affect consolidated near-term financial condition, operating results or cash flows as of December 31, 2019.

Evaluation of Foreign Currency and Commodity Risk

As of each of December 31, 2019 and 2018, the Company did not have any material foreign currency exchange rate or commodity derivative instruments in place and believes its exposure to foreign currency exchange rate risk and commodity price risk is not material.

Evaluation of Operational Risks

The Company also faces certain operational risks, including risks related to information security, including cybersecurity. The Company and its vendors have experienced and continue to experience a variety of cyber attacks, and the Company and its vendors expect to continue to experience cyber attacks going forward. Among other things, the Company and its vendors have experienced automated attempts to gain access to public facing networks, brute force, SYN flood and distributed denial of service attacks, attempted malware infections, vulnerability scanning, ransomware attacks, spear-phishing campaigns, mass reconnaissance attempts, injection attempts, phishing, PHP injection and cross-site scripting. The Company also has seen an increase in attacks designed to obtain access to consumers' accounts using illegally obtained demographic information. The Company is dedicating and will continue to dedicate significant resources and incur significant expenses to maintain and update on an ongoing basis the systems and processes that are designed to mitigate the information security risks it faces and protect the security of its computer systems, software, networks and other technology assets against attempts by unauthorized parties to obtain access to confidential information, destroy data, disrupt or degrade service, sabotage systems or cause other damage. The impact of cyber attacks has not been material to the Company's operations or operating results through December 31, 2019. The Board and its Audit Committee (the "Audit Committee") and Nominating and Corporate Governance Committee are regularly informed regarding the Company's information security policies, practices and status.

Item 8. Financial Statements and Supplementary Data.

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Consolidated Statements of Operations

In millions, except per share amounts	For the Years Ended December 31, 2019	2018	2017
Revenues:			
Products	$ 185,236	$ 183,910	$ 180,063
Premiums	63,122	8,184	3,558
Services	7,407	1,825	1,144
Net investment income	1,011	660	21
Total revenues	256,776	194,579	184,786
Operating costs:			
Cost of products sold	158,719	156,447	153,448
Benefit costs	52,529	6,594	2,810
Goodwill impairments	—	6,149	181
Operating expenses	33,541	21,368	18,809
Total operating costs	244,789	190,558	175,248
Operating income	11,987	4,021	9,538
Interest expense	3,035	2,619	1,062
Loss on early extinguishment of debt	79	—	—
Other expense (income)	(124)	(4)	208
Income before income tax provision	8,997	1,406	8,268
Income tax provision	2,366	2,002	1,637
Income (loss) from continuing operations	6,631	(596)	6,631
Loss from discontinued operations, net of tax	—	—	(8)
Net income (loss)	6,631	(596)	6,623
Net (income) loss attributable to noncontrolling interests	3	2	(1)
Net income (loss) attributable to CVS Health	$ 6,634	$ (594)	$ 6,622
Basic earnings (loss) per share:			
Income (loss) from continuing operations attributable to CVS Health	$ 5.10	$ (0.57)	$ 6.48
Loss from discontinued operations attributable to CVS Health	$ —	$ —	$ (0.01)
Net income (loss) attributable to CVS Health	$ 5.10	$ (0.57)	$ 6.47
Weighted average basic shares outstanding	1,301	1,044	1,020
Diluted earnings (loss) per share:			
Income (loss) from continuing operations attributable to CVS Health	$ 5.08	$ (0.57)	$ 6.45
Loss from discontinued operations attributable to CVS Health	$ —	$ —	$ (0.01)
Net income (loss) attributable to CVS Health	$ 5.08	$ (0.57)	$ 6.44
Weighted average diluted shares outstanding	1,305	1,044	1,024
Dividends declared per share	$ 2.00	$ 2.00	$ 2.00

See accompanying notes to consolidated financial statements.

Consolidated Statements of Comprehensive Income (Loss)

	For the Years Ended December 31,		
In millions	**2019**	**2018**	**2017**
Net income (loss)	$ 6,631	$ (596)	$ 6,623
Other comprehensive income (loss), net of tax:			
Net unrealized investment gains	677	97	—
Foreign currency translation adjustments	162	(29)	(2)
Net cash flow hedges	(33)	330	(10)
Pension and other postretirement benefits	111	(124)	152
Other comprehensive income	917	274	140
Comprehensive income (loss)	7,548	(322)	6,763
Comprehensive (income) loss attributable to noncontrolling interests	3	2	(1)
Comprehensive income (loss) attributable to CVS Health	$ 7,551	$ (320)	$ 6,762

See accompanying notes to consolidated financial statements.

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Consolidated Balance Sheets

In millions, except per share amounts	At December 31, 2019	At December 31, 2018
Assets:		
Cash and cash equivalents	$ 5,683	$ 4,059
Investments	2,373	2,522
Accounts receivable, net	19,617	17,631
Inventories	17,516	16,450
Other current assets	5,113	4,581
Total current assets	50,302	45,243
Long-term investments	17,314	15,732
Property and equipment, net	12,044	11,349
Operating lease right-of-use assets	20,860	—
Goodwill	79,749	78,678
Intangible assets, net	33,121	36,524
Separate accounts assets	4,459	3,884
Other assets	4,600	5,046
Total assets	$ 222,449	$ 196,456
Liabilities:		
Accounts payable	$ 10,492	$ 8,925
Pharmacy claims and discounts payable	13,601	11,365
Health care costs payable	6,879	6,147
Policyholders' funds	2,991	2,939
Accrued expenses	12,133	10,711
Other insurance liabilities	1,830	1,937
Current portion of operating lease liabilities	1,596	—
Short-term debt	—	720
Current portion of long-term debt	3,781	1,265
Total current liabilities	53,303	44,009
Long-term operating lease liabilities	18,926	—
Long-term debt	64,699	71,444
Deferred income taxes	7,294	7,677
Separate accounts liabilities	4,459	3,884
Other long-term insurance liabilities	7,436	8,119
Other long-term liabilities	2,162	2,780
Total liabilities	158,279	137,913
Commitments and contingencies (Note 16)		
Shareholders' equity:		
Preferred stock, par value $0.01: 0.1 shares authorized; none issued or outstanding	—	—
Common stock, par value $0.01: 3,200 shares authorized; 1,727 shares issued and 1,302 shares outstanding at December 31, 2019 and 1,720 shares issued and 1,295 shares outstanding at December 31, 2018 and capital surplus	45,972	45,440
Treasury stock, at cost: 425 shares at both December 31, 2019 and 2018	(28,235)	(28,228)
Retained earnings	45,108	40,911
Accumulated other comprehensive income	1,019	102

Total CVS Health shareholders' equity	63,864	58,225
Noncontrolling interests	306	318
Total shareholders' equity	64,170	58,543
Total liabilities and shareholders' equity	$ 222,449	$ 196,456

See accompanying notes to consolidated financial statements.

Consolidated Statements of Cash Flows

In millions	For the Years Ended December 31, 2019	2018	2017
Cash flows from operating activities:			
Cash receipts from customers	$ 248,393	$ 186,519	$ 176,594
Cash paid for inventory and prescriptions dispensed by retail network pharmacies	(149,655)	(148,981)	(146,469)
Insurance benefits paid	(52,242)	(6,897)	(2,810)
Cash paid to other suppliers and employees	(28,932)	(17,234)	(15,348)
Interest and investment income received	955	644	21
Interest paid	(2,954)	(2,803)	(1,072)
Income taxes paid	(2,717)	(2,383)	(2,909)
Net cash provided by operating activities	12,848	8,865	8,007
Cash flows from investing activities:			
Proceeds from sales and maturities of investments	7,049	817	61
Purchases of investments	(7,534)	(692)	(137)
Purchases of property and equipment	(2,457)	(2,037)	(1,918)
Proceeds from sale-leaseback transactions	5	—	265
Acquisitions (net of cash acquired)	(444)	(42,226)	(1,181)
Proceeds from sale of subsidiary and other assets	—	832	—
Other	42	21	33
Net cash used in investing activities	(3,339)	(43,285)	(2,877)
Cash flows from financing activities:			
Net repayments of short-term debt	(720)	(556)	(598)
Proceeds from issuance of long-term debt	3,736	44,343	—
Repayments of long-term debt	(8,336)	(5,522)	—
Derivative settlements	(25)	446	—
Repurchase of common stock	—	—	(4,361)
Dividends paid	(2,603)	(2,038)	(2,049)
Proceeds from exercise of stock options	210	242	329
Payments for taxes related to net share settlement of equity awards	(112)	(97)	(71)
Other	—	1	(1)
Net cash provided by (used in) financing activities	(7,850)	36,819	(6,751)
Effect of exchange rate changes on cash, cash equivalents and restricted cash	—	(4)	1
Net increase (decrease) in cash, cash equivalents and restricted cash	1,659	2,395	(1,620)
Cash, cash equivalents and restricted cash at the beginning of the period	4,295	1,900	3,520
Cash, cash equivalents and restricted cash at the end of the period	$ 5,954	$ 4,295	$ 1,900

In millions	For the Years Ended December 31, 2019	2018	2017
Reconciliation of net income (loss) to net cash provided by operating activities:			
Net income (loss)	$ 6,631	$ (596)	$ 6,623
Adjustments required to reconcile net income (loss) to net cash provided by operating activities:			
Depreciation and amortization	4,371	2,718	2,479
Goodwill impairments	—	6,149	181
Loss on settlement of defined benefit pension plans	—	—	187
Stock-based compensation	453	280	234
Loss on sale of subsidiary	205	86	—
Loss on early extinguishment of debt	79	—	—
Deferred income taxes	(654)	87	(1,334)
Other noncash items	264	253	53
Change in operating assets and liabilities, net of effects from acquisitions:			
Accounts receivable, net	(2,158)	(1,139)	(941)
Inventories	(1,075)	(1,153)	(514)
Other assets	(614)	(3)	(338)
Accounts payable and pharmacy claims and discounts payable	3,550	2,329	1,710
Health care costs payable and other insurance liabilities	320	(311)	—
Other liabilities	1,476	165	(333)
Net cash provided by operating activities	$ 12,848	$ 8,865	$ 8,007

See accompanying notes to consolidated financial statements.

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Consolidated Statements of Shareholders' Equity

	Number of shares outstanding		Attributable to CVS Health						
In millions	Common Shares	Treasury Shares [1]	Common Stock and Capital Surplus [2]	Treasury Stock [1]	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total CVS Health Shareholders' Equity	Noncontrolling Interests	Total Shareholders' Equity
Balance at December 31, 2016	**1,705**	**(644)**	**$ 31,635**	**$ (33,483)**	**$ 38,983**	**$ (305)**	**$ 36,830**	**$ 4**	**$ 36,834**
Net income	—	—	—	—	6,622	—	6,622	1	6,623
Other comprehensive income (Note 13)	—	—	—	—	—	140	140	—	140
Stock option activity, stock awards and other	7	—	461	—	—	—	461	—	461
Purchase of treasury shares, net of ESPP issuances	—	(54)	—	(4,313)	—	—	(4,313)	—	(4,313)
Common stock dividends	—	—	—	—	(2,049)	—	(2,049)	—	(2,049)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(1)	(1)
Balance at December 31, 2017	1,712	(698)	32,096	(37,796)	43,556	(165)	37,691	4	37,695
Adoption of new accounting standards [3]	—	—	—	—	(6)	(7)	(13)	—	(13)
Net loss	—	—	—	—	(594)	—	(594)	(2)	(596)
Other comprehensive income (Note 13)	—	—	—	—	—	274	274	—	274
Common shares issued to acquire Aetna	—	274	12,923	9,561	—	—	22,484	—	22,484
Stock option activity, stock awards and other	8	—	421	—	—	—	421	—	421
Purchase of treasury shares, net of ESPP issuances	—	(1)	—	7	—	—	7	—	7
Common stock dividends	—	—	—	—	(2,045)	—	(2,045)	—	(2,045)
Acquisition of noncontrolling interests	—	—	—	—	—	—	—	329	329
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(13)	(13)
Balance at December 31, 2018	1,720	(425)	45,440	(28,228)	40,911	102	58,225	318	58,543
Adoption of new accounting standards (Note 1)	—	—	—	—	178	—	178	—	178
Net income (loss)	—	—	—	—	6,634	—	6,634	(3)	6,631
Other comprehensive income (Note 13)	—	—	—	—	—	917	917	—	917
Stock option activity, stock awards and other	7	2	532	—	—	—	532	—	532
Purchase of treasury shares, net of ESPP issuances	—	(2)	—	(7)	—	—	(7)	—	(7)
Common stock dividends	—	—	—	—	(2,615)	—	(2,615)	—	(2,615)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(9)	(9)
Balance at December 31, 2019	**1,727**	**(425)**	**$ 45,972**	**$ (28,235)**	**$ 45,108**	**$ 1,019**	**$ 63,864**	**$ 306**	**$ 64,170**

(1) Treasury shares include 1 million shares held in trust for each of the years ended December 31, 2019, 2018 and 2017. Treasury stock includes $29 million related to shares held in trust for each of the years ended December 31, 2019 and 2018 and $31 million related to shares held in trust for the year ended December 31, 2017. See Note 1 "Significant Accounting Policies" for additional information.

(2) Common stock and capital surplus includes the par value of common stock of $17 million as of December 31, 2019, 2018 and 2017.

(3) Reflects the adoption of Accounting Standards Update ("ASU") 2014-09, *Revenue from Contracts with Customers*, which resulted in a reduction to retained earnings of $13 million and the adoption of ASU 2018-02, *Income Statement - Reporting Comprehensive Income (Topic 220): Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income*, which resulted in a reduction to accumulated other comprehensive income of $7 million and an increase to retained earnings of $7 million, each during the year ended December 31, 2018.

See accompanying notes to consolidated financial statements.

Notes to Consolidated Financial Statements

1. Significant Accounting Policies

Description of Business

CVS Health Corporation ("CVS Health"), together with its subsidiaries (collectively, "Company"), has approximately 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 105 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year and expanding specialty pharmacy services. CVS Health also serves an estimated 37 million people through traditional, voluntary and consumer-directed health insurance products and related services, including expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

On November 28, 2018 (the "Aetna Acquisition Date"), the Company acquired Aetna Inc. ("Aetna"). As a result of the acquisition of Aetna (the "Aetna Acquisition"), the Company added the Health Care Benefits segment. Certain aspects of Aetna's operations, including products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, are included in the Company's Corporate/Other segment. The consolidated financial statements reflect Aetna's results subsequent to the Aetna Acquisition Date.

Effective for the first quarter of 2019, the Company realigned the composition of its segments to correspond with changes to its operating model and reflect how its Chief Operating Decision Maker (the "CODM") reviews information and manages the business. As a result of this realignment, the Company's SilverScript® PDP moved from the Pharmacy Services segment to the Health Care Benefits segment. In addition, the Company moved Aetna's mail order and specialty pharmacy operations from the Health Care Benefits segment to the Pharmacy Services segment. Segment financial information has been retrospectively adjusted to reflect these changes.

The Company has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other, which are described below.

Pharmacy Services Segment
The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services, mail order pharmacy, specialty pharmacy and infusion services, clinical services, disease management services and medical spend management. The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Medicaid managed care plans, plans offered on public health insurance exchanges ("Public Exchanges") and private health insurance exchanges, other sponsors of health benefit plans and individuals throughout the United States. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services.

Retail/LTC Segment
The Retail/LTC segment sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products, cosmetics and personal care products, provides health care services through its MinuteClinic® walk-in medical clinics and conducts long-term care pharmacy ("LTC") operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. As of December 31, 2019, the Retail/LTC segment operated approximately 9,900 retail locations, approximately 1,100 MinuteClinic® locations as well as online retail pharmacy websites, LTC pharmacies and onsite pharmacies.

Health Care Benefits Segment
The Health Care Benefits segment is one of the nation's leading diversified health care benefits providers, serving an estimated 37 million people as of December 31, 2019. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make more informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-

directed health insurance products and related services, including medical, pharmacy, dental and behavioral health plans, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services, workers' compensation administrative services and health information technology products and services. The Health Care Benefit segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates. The Company refers to insurance

products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk for medical and dental care costs) as "ASC." For periods prior to November 28, 2018 (the Aetna Acquisition Date), the Health Care Benefits segment was comprised of the Company's SilverScript PDP business.

Corporate/Other Segment
The Company presents the remainder of its financial results in the Corporate/Other segment, which consists of:

- Management and administrative expenses to support the overall operations of the Company, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments, expenses associated with the Company's investments in its transformation and Enterprise modernization programs and acquisition-related transaction and integration costs; and

- Products for which the Company no longer solicits or accepts new customers such as its large case pensions and long-term care insurance products.

Basis of Presentation

The accompanying consolidated financial statements of CVS Health and its subsidiaries have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP"). The consolidated financial statements include the accounts of the Company and its majority-owned subsidiaries and variable interest entities ("VIEs") for which the Company is the primary beneficiary. All material intercompany balances and transactions have been eliminated.

Reclassifications

Certain prior year amounts have been reclassified to conform with the current year presentation.

Use of Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and temporary investments with maturities of three months or less when purchased. The Company invests in short-term money market funds, commercial paper and time deposits, as well as other debt securities that are classified as cash equivalents within the accompanying consolidated balance sheets, as these funds are highly liquid and readily convertible to known amounts of cash.

Restricted Cash

Restricted cash included in other current assets on the consolidated balance sheets represents amounts held in escrow accounts in connection with certain recent acquisitions. Restricted cash included in other assets on the consolidated balance sheets represents amounts held in a trust in one of the Company's captive insurance companies to satisfy collateral requirements associated with the assignment of certain insurance policies. All restricted cash is invested in time deposits, money market funds or commercial paper.

The following is a reconciliation of cash and cash equivalents on the consolidated balance sheets to total cash, cash equivalents and restricted cash on the consolidated statements of cash flows as of December 31, 2019, 2018 and 2017:

In millions	**2019**	**2018**	**2017**
Cash and cash equivalents	$ 5,683	$ 4,059	$ 1,696
Restricted cash (included in other current assets)	—	6	14
Restricted cash (included in other assets)	271	230	190

Total cash, cash equivalents and restricted cash at the end of the period in the consolidated statements of cash flows	$ 5,954	$ 4,295	$ 1,900

Investments

Debt Securities
Debt securities consist primarily of U.S. Treasury and agency securities, mortgage-backed securities, corporate and foreign bonds and other debt securities. Debt securities are classified as either current or long-term investments based on their contractual maturities unless the Company intends to sell an investment within the next twelve months, in which case it is classified as current on the consolidated balance sheets. Debt securities are classified as available for sale and are carried at fair value. See Note 4 ‘‘Fair Value’’ for additional information on how the Company estimates the fair value of these investments.

The cost for mortgage-backed and other asset-backed securities is adjusted for unamortized premiums and discounts, which are amortized using the interest method over the estimated remaining term of the securities, adjusted for anticipated prepayments.

The Company regularly reviews its debt securities to determine whether a decline in fair value below the cost basis or carrying value is other-than-temporary. When a debt security is in an unrealized capital loss position, the Company monitors the duration and severity of the loss to determine if sufficient market recovery can occur within a reasonable period of time. If a decline in the fair value of a debt security is considered other-than-temporary, the cost basis or carrying value of the debt security is written down. The write-down is then bifurcated into its credit and non-credit related components. The amount of the credit-related component is included in the Company’s net income (loss), and the amount of the non-credit related component is included in other comprehensive income (loss), unless the Company intends to sell the debt security or it is more likely than not that the Company will be required to sell the debt security prior to its anticipated recovery of the debt security’s amortized cost basis. Interest is not accrued on debt securities when management believes the collection of interest is unlikely.

Equity Securities
Equity securities with readily available fair values are measured at fair value with changes in fair value recognized in net income (loss).

Mortgage Loans
Mortgage loan investments on the consolidated balance sheets are valued at the unpaid principal balance, net of impairment reserves. A mortgage loan may be impaired when it is a problem loan (i.e., more than 60 days delinquent, in bankruptcy or in process of foreclosure), a potential problem loan (i.e., high probability of default) or a restructured loan. For impaired loans, a specific impairment reserve is established for the difference between the recorded investment in the loan and the estimated fair value of the collateral. The Company applies its loan impairment policy individually to all loans in its portfolio.

The impairment evaluation described above also considers characteristics and risk factors attributable to the aggregate portfolio. An additional allowance for loan losses is established if it is probable that there will be a credit loss on a group of similar mortgage loans. The following characteristics and risk factors are considered when evaluating if a credit loss is probable on a group of similar mortgage loans: loan-to-value ratios, property type (e.g., office, retail, apartment, industrial), geographic location, vacancy rates and property condition.

Full or partial impairments of loans are recorded at the time an event occurs affecting the legal status of the loan, typically at the time of foreclosure or upon a loan modification giving rise to forgiveness of debt. Interest income on a potential problem loan or restructured loan is accrued to the extent it is deemed to be collectible and the loan continues to perform under its original or restructured terms. Interest income on problem loans is recognized on a cash basis. Cash payments on loans in the process of foreclosure are treated as a return of principal. Mortgage loans with a maturity date or a committed prepayment date within twelve months are classified as current on the consolidated balance sheets.

Other Investments
Other investments consist primarily of the following:

- Private equity and hedge fund limited partnerships, which are accounted for using the equity method of accounting. Under this method, the carrying value of the investment is based on the value of the Company’s equity ownership of the underlying investment funds provided by the general partner or manager of the investments, the financial statements of which generally are audited. As a result of the timing of the receipt of the valuation information provided by the fund managers, these investments are generally reported on up to a

three month lag. The Company reviews investments for impairment at least quarterly and monitors their performance throughout the year through discussions with the administrators, managers and/or general partners. If the Company becomes aware of an impairment of a limited partnership's investments through its review or prior to receiving the limited partnership's financial statements at the

financial statement date, an impairment will be recognized by recording a reduction in the carrying value of the limited partnership with a corresponding charge to net investment income.

- Investment real estate, which is carried on the consolidated balance sheets at depreciated cost, including capital additions, net of write-downs for other-than-temporary declines in fair value. Depreciation is calculated using the straight-line method based on the estimated useful life of each asset. If any real estate investment is considered held-for-sale, it is carried at the lower of its carrying value or fair value less estimated selling costs. The Company generally estimates fair value using a discounted future cash flow analysis in conjunction with comparable sales information. At the time of the sale, the difference between the sales price and the carrying value is recorded as a realized capital gain or loss.

- Privately-placed equity securities, which are carried on the consolidated balance sheets at cost less impairments, plus or minus subsequent adjustments for observable price changes. Additionally, as a member of the Federal Home Loan Bank of Boston ("FHLBB"), a subsidiary of the Company is required to purchase and hold shares of the FHLBB. These shares are restricted and carried at cost.

Net Investment Income

Net investment income on the Company's investments is recorded when earned and is reflected in the Company's net income (loss) (other than net investment income on assets supporting experience-rated products). Experience-rated products are products in the large case pensions business where the contract holder, not the Company, assumes investment and other risks, subject to, among other things, minimum guarantees provided by the Company. The effect of investment performance on experience-rated products is allocated to contract holders' accounts daily, based on the underlying investment experience and, therefore, does not impact the Company's net income (loss) (as long as the contract's minimum guarantees are not triggered). Net investment income on assets supporting large case pensions' experience-rated products is included in net investment income in the consolidated statements of operations and is credited to contract holders' accounts through a charge to benefit costs.

Realized capital gains and losses on investments (other than realized capital gains and losses on investments supporting experience-rated products) are included as a component of net investment income in the consolidated statements of operations. Realized capital gains and losses are determined on a specific identification basis. Purchases and sales of debt and equity securities and alternative investments are reflected on the trade date. Purchases and sales of mortgage loans and investment real estate are reflected on the closing date.

Realized capital gains and losses on investments supporting large case pensions' experience-rated products are not included in realized capital gains and losses in the consolidated statements of operations and instead are credited directly to contract holders' accounts. The contract holders' accounts are reflected in policyholders' funds on the consolidated balance sheets.

Unrealized capital gains and losses on investments (other than unrealized capital gains and losses on investments supporting experience-rated products) are reflected in shareholders' equity, net of tax, as a component of accumulated other comprehensive income. Unrealized capital gains and losses on investments supporting large case pensions' experience-rated products are credited directly to contract holders' accounts. The contract holders' accounts are reflected in policyholders' funds on the consolidated balance sheets.

Derivative Financial Instruments

The Company uses derivative financial instruments in order to manage interest rate and foreign exchange risk and credit exposure. The Company's use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps.

Accounts Receivable

Accounts receivable are stated net of allowances for doubtful accounts, customer credit allowances, contractual allowances and estimated terminations. Accounts receivable, net is composed of the following at December 31, 2019 and 2018:

In millions	2019	2018
Trade receivables	$ 6,717	$ 6,497
Vendor and manufacturer receivables	7,856	7,315
Premium receivables	2,663	2,259
Other receivables	2,381	1,560
Total accounts receivable, net	$ 19,617	$ 17,631

The activity in the allowance for doubtful accounts receivable for the years ended December 31, 2019, 2018 and 2017 is as follows:

In millions	2019	2018	2017
Beginning balance	$ 287	$ 162	$ 158
Additions charged to bad debt expense	111	162	139
Write-offs charged to allowance	(79)	(37)	(135)
Ending balance	$ 319	$ 287	$ 162

Inventories

Inventories are valued at the lower of cost or net realizable value using the weighted average cost method. Physical inventory counts are taken on a regular basis in each retail store and LTC pharmacy, and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the consolidated financial statements are properly stated. During the interim period between physical inventory counts, the Company accrues for anticipated physical inventory losses on a location-by-location basis based on historical results and current physical inventory trends.

Reinsurance Recoverables

The Company utilizes reinsurance agreements primarily to: (a) reduce required capital and (b) facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit the Company to recover a portion of its losses from reinsurers, although they do not discharge the Company's primary liability as the direct insurer of the risks reinsured. Failure of reinsurers to indemnify the Company could result in losses; however, the Company does not expect charges for unrecoverable reinsurance to have a material effect on its consolidated operating results or financial condition. The Company evaluates the financial condition of its reinsurers and monitors concentrations of credit risk arising from similar geographic regions, activities or economic characteristics of its reinsurers. At December 31, 2019, the Company's reinsurance recoverables consisted primarily of amounts due from third parties that are rated consistent with companies that are considered to have the ability to meet their obligations. Reinsurance recoverables are recorded as other current assets or other assets on the consolidated balance sheets.

Health Care Contract Acquisition Costs

Insurance products included in the Health Care Benefits segment are cancelable by either the customer or the member monthly upon written notice. Acquisition costs related to prepaid health care and health indemnity contracts are generally expensed as incurred. Acquisition costs for certain long-duration insurance contracts are deferred and are recorded as other current assets or other assets on the consolidated balance sheets and are amortized over the estimated life of the contracts. The amortization of deferred acquisition costs is recorded in operating expenses in the consolidated statements of operations. At December 31, 2019 and 2018, the balance of deferred acquisition costs was $271 million and $22 million, respectively, comprised primarily of commissions paid on Medicare Supplement products within the Health Care Benefits segment.

Property and Equipment

Property and equipment is reported at historical cost, net of accumulated depreciation. Property, equipment and improvements to leased premises are depreciated using the straight-line method over the estimated useful lives of the assets, or when applicable, the term of the lease, whichever is shorter. Estimated useful lives generally range from 1 to 40 years for buildings, building improvements and leasehold improvements and 3 to 10 years for fixtures, equipment and internally developed software. Repair and maintenance costs are charged directly to expense as incurred. Major renewals or replacements that substantially extend the useful life of an asset are capitalized and depreciated. Application development stage costs for significant internally developed software projects are capitalized and depreciated.

Property and equipment consists of the following at December 31, 2019 and 2018:

In millions	**2019**	**2018**
Land	$ 1,981	$ 1,872
Building and improvements	4,068	3,785
Fixtures and equipment	13,807	13,028
Leasehold improvements	5,611	5,384
Software	3,467	2,800
Total property and equipment	28,934	26,869
Accumulated depreciation and amortization	(16,890)	(15,520)
Property and equipment, net	$ 12,044	$ 11,349

Depreciation expense (which includes the amortization of property and equipment under finance or capital leases) totaled $1.9 billion in the year ended December 31, 2019 and $1.7 billion in each of the years ended December 31, 2018 and 2017. See Note 6 ‘‘Leases’’ for additional information about finance and capital leases.

Right-of-Use Assets and Lease Liabilities

The Company determines if an arrangement contains a lease at the inception of a contract. Right-of-use assets represent the Company’s right to use an underlying asset for the lease term and lease liabilities represent the Company’s obligation to make lease payments arising from the lease. Right-of-use assets and lease liabilities are recognized at the commencement date of the lease, renewal date of the lease or significant remodeling of the lease space based on the present value of the remaining future minimum lease payments. As the interest rate implicit in the Company’s leases is not readily determinable, the Company utilizes its incremental borrowing rate, determined by class of underlying asset, to discount the lease payments. The operating lease right-of-use assets also include lease payments made before commencement and are reduced by lease incentives.

The Company’s real estate leases typically contain options that permit renewals for additional periods of up to five years each. For real estate leases, the options to extend are not considered reasonably certain at lease commencement because the Company reevaluates each lease on a regular basis to consider the economic and strategic incentives of exercising the renewal options and regularly opens or closes stores to align with its operating strategy. Generally, the renewal option periods are not included within the lease term and the associated payments are not included in the measurement of the right-of-use asset and lease liability. Similarly, renewal options are not included in the lease term for non-real estate leases because they are not considered reasonably certain of being exercised at lease commencement. Leases with an initial term of 12 months or less are not recorded on the balance sheets, and lease expense is recognized on a straight-line basis over the term of the short-term lease.

For real estate leases, the Company accounts for lease components and nonlease components as a single lease component. Certain real estate leases require additional payments based on sales volume, as well as reimbursement for real estate taxes, common area maintenance and insurance, which are expensed as incurred as variable lease costs. Other real estate leases contain one fixed lease payment that includes real estate taxes, common area maintenance and insurance. These fixed payments are considered part of the lease payment and included in the right-of-use assets and lease liabilities.

See Note 6 ‘‘Leases’’ for additional information about right-of-use assets and lease liabilities.

Goodwill

The Company accounts for business combinations using the acquisition method of accounting, which requires the excess cost of an acquisition over the fair value of net assets acquired and identifiable intangible assets to be recorded as goodwill. Goodwill is not amortized, but is subject to impairment reviews annually, or more frequently if necessary, as further described below. See Note 5 ‘‘Goodwill and Other Intangibles’’ for additional information about goodwill.

Intangible Assets

The Company’s identifiable intangible assets consist primarily of trademarks, trade names, customer contracts/ relationships, covenants not to compete, technology, provider networks and value of business acquired (“VOBA”). These intangible assets arise primarily from the determination of their respective fair market values at the date of acquisition. Amounts assigned to identifiable intangible assets, and their related useful lives, are derived from established valuation techniques and management estimates.

The Company’s definite-lived intangible assets are amortized over their estimated useful lives based upon the pattern of future cash flows attributable to the asset. Other than VOBA, definite-lived intangible assets are amortized using the straight-line method. VOBA is amortized over the expected life of the acquired contracts in proportion to estimated premiums. Indefinite-lived intangible assets are not amortized but are tested for impairment annually, or more frequently if necessary, as further described in “Long-Lived Asset Impairment” below.

See Note 5 ‘‘Goodwill and Other Intangibles’’ for additional information about intangible assets.

Long-Lived Asset Impairment

The Company evaluates the recoverability of long-lived assets, excluding goodwill and indefinite-lived intangible assets, which are tested for impairment using separate tests described below, whenever events or changes in circumstances indicate that the carrying value of such asset may not be recoverable. The Company groups and evaluates these long-lived assets for impairment at the lowest level at which individual cash flows can be identified. If indicators of impairment are present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted and without interest charges). If the estimated future cash flows used in this analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group’s estimated future cash flows (discounted and with interest charges). If required, an impairment loss is recorded for the portion of the asset group’s carrying value that exceeds the asset group’s estimated future cash flows (discounted and with interest charges). During the year ended December 31, 2019, the Company recorded store rationalization charges of $231 million, primarily related to operating lease right-of-use asset impairment charges. See Note 6 ‘‘Leases’’ for additional information about the right-of-use asset impairment charges. During the year ended December 31, 2018, the Company recognized a $43 million long-lived asset impairment charge, primarily related to the impairment of property and equipment. There were no material impairment charges recognized on long-lived assets in the year ended December 31, 2017.

When evaluating goodwill for potential impairment, the Company compares the fair value of its reporting units to their respective carrying amounts. The Company estimates the fair value of its reporting units using a combination of a discounted cash flow method and a market multiple method. If the carrying amount of a reporting unit exceeds its estimated fair value, an impairment loss is recognized in an amount equal to that excess. During the third quarter of 2019, the Company performed its required annual goodwill impairment tests and concluded there were no goodwill impairments as of the testing date. See Note 5 ‘‘Goodwill and Other Intangibles’’ for additional information about goodwill impairment charges recorded during the years ended December 31, 2018 and 2017.

Indefinite-lived intangible assets are tested for impairment by comparing the estimated fair value of the asset to its carrying value. The Company estimates the fair value of its indefinite-lived trademarks using the relief from royalty method under the income approach. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized, and the asset is written down to its estimated fair value. There were no impairment losses recognized on indefinite-lived intangible assets in any of the years ended December 31, 2019, 2018 or 2017.

Separate Accounts

Separate Accounts assets and liabilities related to large case pensions products represent funds maintained to meet specific objectives of contract holders who bear the investment risk. These assets and liabilities are carried at fair value. Net investment income (including net realized capital gains and losses) accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from the Company's other businesses. Deposits, withdrawals and net investment income (including net realized and net unrealized capital gains and losses) on Separate Accounts assets are not reflected in the consolidated statements of operations or cash flows. Management fees charged to contract holders are included in services revenue and recognized over the period earned.

Health Care Costs Payable

Health care costs payable consist principally of unpaid fee-for-service medical, dental and pharmacy claims, capitation costs, other amounts due to health care providers pursuant to risk-sharing arrangements related to the Health Care Benefits segment's Insured Commercial, Medicare and Medicaid products and accruals for state assessments. Unpaid health care claims include an estimate of payments the Company will make for (i) services rendered to the Company's Insured members but not yet reported to the Company and (ii) claims which have been reported to the Company but not yet paid, each as of the financial statement date (collectively, "IBNR"). Health care costs payable also include an estimate of the cost of services that will continue to be rendered after the financial statement date if the Company is obligated to pay for such services in accordance with contractual or regulatory requirements. Such estimates are developed using actuarial principles and assumptions which consider, among other things, historical and projected claim submission and processing patterns, assumed and historical medical cost trends, historical utilization of medical services, claim inventory levels, changes in Insured membership and product mix, seasonality and other relevant factors. The Company reflects changes in these estimates in benefit costs in the Company's consolidated operating results in the period they are determined. Capitation costs represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the volume of medical services provided to the Insured member. Amounts due under risk-sharing arrangements are based on the terms of the underlying contracts with the providers and consider claims experience under the contracts through the financial statement date.

The Company develops its estimate of IBNR using actuarial principles and assumptions that consider numerous factors. Of those factors, the Company considers the analysis of historical and projected claim payment patterns (including claims submission and processing patterns) and the assumed health care cost trend rate (the year-over-year change in per member per month health care costs) to be the most critical assumptions. In developing its IBNR estimate, the Company consistently applies these actuarial principles and assumptions each period, with consideration to the variability of related factors. There have been no significant changes to the methodologies or assumptions used to develop the Company's estimate of IBNR in 2019.

The Company analyzes historical claim payment patterns by comparing claim incurred dates (i.e., the date services were provided) to claim payment dates to estimate "completion factors." The Company uses completion factors predominantly to estimate the ultimate cost of claims incurred more than three months before the financial statement date. The Company estimates completion factors by aggregating claim data based on the month of service and month of claim payment and estimating the percentage of claims incurred for a given month that are complete by each month thereafter. For any given month, substantially all claims are paid within six months of the date of service, but it can take up to 48 months or longer after the date of service before all of the claims are completely resolved and paid. These historically-derived completion factors are then applied to claims paid through the financial statement date to estimate the ultimate claim cost for a given month's incurred claim activity. The difference between the estimated ultimate claim cost and the claims paid through the financial statement date represents the Company's estimate of claims remaining to be paid as of the financial statement date and is included in the Company's health care costs payable. The completion factors the Company uses reflect judgments and possible adjustments based on data such as claim inventory levels, claim submission and processing patterns and, to a lesser extent, other factors such as changes in health care cost trend rates, changes in Insured membership and changes in product mix. If claims are submitted or processed on a faster (slower) pace than prior periods, the actual claims may be more (less) complete than originally estimated using the Company's completion factors, which may result in reserves that are higher (lower) than the ultimate cost of claims.

Because claims incurred within three months before the financial statement date are less mature, the Company uses a combination of historically-derived completion factors and the assumed health care cost trend rate to estimate the

ultimate cost of claims incurred for these months. The Company applies its actuarial judgment and places a greater emphasis on the assumed health care cost trend rate for the most recent claim incurred dates as these months may be influenced by seasonal patterns and changes in membership and product mix.

The Company's health care cost trend rate is affected by changes in per member utilization of medical services as well as changes in the unit cost of such services. Many factors influence the health care cost trend rate, including the Company's ability to manage benefit costs through product design, negotiation of favorable provider contracts and medical management programs, as well as the mix of the Company's business. The health status of the Company's Insured members, aging of the population and other demographic characteristics, advances in medical technology and other factors continue to contribute to rising per member utilization and unit costs. Changes in health care practices, inflation, new technologies, increases in the cost of prescription drugs (including specialty pharmacy drugs), direct-to-consumer marketing by pharmaceutical companies, clusters of high-cost cases, claim intensity, changes in the regulatory environment, health care provider or member fraud and numerous other factors also contribute to the cost of health care and the Company's health care cost trend rate.

For each reporting period, the Company uses an extensive degree of judgment in the process of estimating its health care costs payable. As a result, considerable variability and uncertainty is inherent in such estimates, particularly with respect to claims with claim incurred dates of three months or less before the financial statement date; and the adequacy of such estimates is highly sensitive to changes in assumed completion factors and the assumed health care cost trend rates. For each reporting period the Company recognizes the actuarial best estimate of health care costs payable considering the potential volatility in assumed completion factors and health care cost trend rates, as well as other factors. The Company believes its estimate of health care costs payable is reasonable and adequate to cover its obligations at December 31, 2019; however, actual claim payments may differ from the Company's estimates. A worsening (or improvement) of the Company's health care cost trend rates or changes in completion factors from those that the Company assumed in estimating health care costs payable at December 31, 2019 would cause these estimates to change in the near term, and such a change could be material.

Each quarter, the Company re-examines previously established health care costs payable estimates based on actual claim payments for prior periods and other changes in facts and circumstances. Given the extensive degree of judgment in this estimate, it is possible that the Company's estimates of health care costs payable could develop either favorably (that is, its actual benefit costs for the period were less than estimated) or unfavorably. The changes in the Company's estimate of health care costs payable may relate to a prior quarter, prior year or earlier periods. For a roll forward of the Company's health care costs payable, see Note 7 ''Health Care Costs Payable.'' The Company's reserving practice is to consistently recognize the actuarial best estimate of its ultimate liability for health care costs payable.

Other Insurance Liabilities

Unpaid Claims

Unpaid claims consist primarily of reserves associated with certain short-duration group disability and term life insurance contracts, including an estimate for IBNR as of the financial statement date. Reserves associated with certain short-duration group disability and term life insurance contracts are based upon the Company's estimate of the present value of future benefits, which is based on assumed investment yields and assumptions regarding mortality, morbidity and recoveries from the U.S. Social Security Administration. The Company develops its estimate of IBNR using actuarial principles and assumptions which consider, among other things, contractual requirements, claim incidence rates, claim recovery rates, seasonality and other relevant factors. The Company discounts certain claim liabilities related to group long-term disability and life insurance waiver of premium contracts. The discount rates generally reflect the Company's expected investment returns for the investments supporting all incurral years of these liabilities. The discount rates for retrospectively-rated contracts are set at contractually specified levels. The Company's estimates of unpaid claims are subject to change due to changes in the underlying experience of the insurance contracts, changes in investment yields or other factors, and these changes are recorded in current and future benefits in the consolidated statements of operations in the period they are determined. The Company estimates its reserve for claims IBNR for life products largely based on completion factors. The completion factors used are based on the Company's historical experience and reflect judgments and possible adjustments based on data such as claim inventory levels, claim payment patterns, changes in business volume and other factors. If claims are submitted or processed on a faster (slower) pace than historical periods, the actual claims may be more (less) complete than originally estimated using completion factors, which may result in reserves that are higher (lower) than required to cover future life benefit payments. There have been no significant changes to the methodologies or assumptions used to develop the Company's estimate of unpaid claims IBNR in 2019. As of December 31, 2019, unpaid claims balances of $704 million and $1.8 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively. As of December 31, 2018, unpaid claims balances of $816 million and $1.9 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively.

Substantially all life and disability insurance liabilities have been fully ceded to unrelated third parties through indemnity reinsurance agreements; however, the Company remains directly obligated to the policyholders.

Future Policy Benefits
Future policy benefits consist primarily of reserves for limited payment pension and annuity contracts and long-term care insurance contracts. Reserves for limited payment pension and annuity contracts are computed using actuarial principles that consider, among other things, assumptions reflecting anticipated mortality, retirement, expense and interest rate experience. Such assumptions generally vary by plan, year of issue and policy duration. Assumed interest rates on such contracts ranged from 3.5% to 11.3% in the year ended December 31, 2019 and from the Aetna Acquisition Date through December 31, 2018. The Company periodically reviews mortality assumptions against both industry standards and its experience. Reserves for long-duration long-term care contracts represent the Company's estimate of the present value of future benefits to be paid to or on behalf of policyholders less the present value of future net premiums. The assumed interest rate on such contracts was 5.1% in the year ended December 31, 2019 and from the Aetna Acquisition Date through December 31, 2018. The Company's estimate of the present value of future benefits under such contracts is based upon mortality, morbidity and interest rate assumptions. As of December 31, 2019, future policy benefits balances of $508 million and $5.6 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively. As of December 31, 2018, future policy benefits balances of $536 million and $6.2 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively.

Premium Deficiency Reserves

The Company evaluates its insurance contracts to determine if it is probable that a loss will be incurred. A premium deficiency loss is recognized when it is probable that expected future claims, including maintenance costs (for example, direct costs such as claim processing costs), will exceed existing reserves plus anticipated future premiums and reinsurance recoveries. Anticipated investment income is considered in the calculation of premium deficiency losses for short-duration contracts. For purposes of determining premium deficiency losses, contracts are grouped consistent with the Company's method of acquiring, servicing and measuring the profitability of such contracts. As of December 31, 2019 and 2018, the Company established a premium deficiency reserve of $4 million and $16 million, respectively, related to Medicaid products in the Health Care Benefits segment.

Policyholders' Funds

Policyholders' funds consist primarily of reserves for pension and annuity investment contracts and customer funds associated with certain health contracts. Reserves for such contracts are equal to cumulative deposits less withdrawals and charges plus interest credited thereon, net of experience-rated adjustments. In 2019, interest rates for pension and annuity investment contracts ranged from 3.5% to 15.0%. From the Aetna Acquisition Date through December 31, 2018, interest rates for pension and annuity investment contracts ranged from 3.5% to 13.4%. Reserves for contracts subject to experience rating reflect the Company's rights as well as the rights of policyholders and plan participants. The Company also holds funds for health savings accounts ("HSAs") on behalf of members associated with high deductible health plans. These amounts are held to pay for qualified health care expenses incurred by these members. The HSA balances were approximately $2.2 billion and $2.1 billion at December 31, 2019 and 2018, respectively, and are reflected in other current assets with a corresponding liability in policyholders' funds.

Policyholders' funds liabilities that are expected to be paid within twelve months from the balance sheet date are classified as current on the consolidated balance sheets. Policyholders' funds liabilities that are expected to be paid greater than twelve months from the balance sheet date are included in other long-term liabilities on the consolidated balance sheets.

Self-Insurance Liabilities

The Company is self-insured for certain losses related to general liability, workers' compensation and auto liability. The Company obtains third party insurance coverage to limit exposure from these claims. The Company is also self-insured for certain losses related to health and medical liabilities. The Company's self-insurance accruals, which include reported claims and claims incurred but not reported, are calculated using standard insurance industry actuarial assumptions and the Company's historical claims experience. At December 31, 2019 and 2018, self-insurance liabilities totaled $856 million and $865 million, respectively, and were recorded as accrued expenses on the consolidated balance sheets.

Foreign Currency Translation and Transactions

For non-U.S. dollar functional currency locations, (i) assets and liabilities are translated at end-of-period exchange rates, (ii) revenues and expenses are translated at average exchange rates in effect during the period and (iii) equity is translated at historical exchange rates. The resulting cumulative translation adjustments are included as a component of accumulated other comprehensive income (loss).

For U.S. dollar functional currency locations, foreign currency assets and liabilities are remeasured into U.S. dollars at end-of-period exchange rates, except for nonmonetary balance sheet accounts which are remeasured at historical exchange rates. Revenues and expenses are remeasured at average exchange rates in effect during each period, except for those expenses related to the nonmonetary balance sheet amounts which are remeasured at historical exchange rates. Gains or losses from foreign currency remeasurement are included in net income (loss).

On July 1, 2019, the Company sold its Brazilian subsidiary, Drogaria Onofre Ltda. ("Onofre") for an immaterial amount. The Company recorded a loss on the divestiture, which included the elimination of the subsidiary's $154 million cumulative translation adjustment from accumulated other comprehensive income. Gains and losses from foreign currency transactions and the effects of foreign currency remeasurements were not material in 2018 or 2017.

Revenue Recognition

Pharmacy Services Segment
The Pharmacy Services segment sells prescription drugs directly through its mail service dispensing pharmacies and indirectly through the Company's retail pharmacy network. The Company's pharmacy benefit arrangements are accounted for in a manner consistent with a master supply arrangement as there are no contractual minimum volumes and each prescription is considered a separate purchasing decision and distinct performance obligation transferred at a point in time. PBM services performed in connection with each prescription claim are considered part of a single performance obligation which culminates in the dispensing of prescription drugs.

The Company recognizes revenue using the gross method at the contract price negotiated with its clients when the Company has concluded it controls the prescription drug before it is transferred to the client plan members. The Company controls prescriptions dispensed indirectly through its retail pharmacy network because it has separate contractual arrangements with those pharmacies, has discretion in setting the price for the transaction and assumes primary responsibility for fulfilling the promise to provide prescription drugs to its client plan members while also performing the related PBM services.

Revenues include (i) the portion of the price the client pays directly to the Company, net of any discounts earned on brand name drugs or other discounts and refunds paid back to the client (see "Drug Discounts" and "Guarantees" below), (ii) the price paid to the Company by client plan members for mail order prescriptions and the price paid to retail network pharmacies by client plan members for retail prescriptions ("retail co-payments"), and (iii) claims based administrative fees for retail pharmacy network contracts. Sales taxes are not included in revenues.

The Company recognizes revenue when control of the prescription drugs is transferred to customers, in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those prescription drugs. The Company has established the following revenue recognition policies for the Pharmacy Services segment:

- Revenues generated from prescription drugs sold by mail service dispensing pharmacies are recognized when the prescription drug is delivered to the client plan member. At the time of delivery, the Company has performed substantially all of its performance obligations under its client contracts and does not experience a significant level of returns or reshipments.
- Revenues generated from prescription drugs sold by third party pharmacies in the Company's retail pharmacy network and associated administrative fees are recognized at the Company's point-of-sale, which is when the claim is adjudicated by the Company's online claims processing system and the Company has transferred control of the prescription drug and performed all of its performance obligations.

For contracts under which the Company acts as an agent or does not control the prescription drugs prior to transfer to the client plan member, revenue is recognized using the net method.

Drug Discounts
The Company records revenue net of manufacturers' rebates earned by its clients based on their plan members' utilization of brand-name formulary drugs. The Company estimates these rebates at period-end based on actual and estimated claims data and its estimates of the manufacturers' rebates earned by its clients. The estimates are based on the best available data at period-end and recent history for the various factors that can affect the amount of rebates due to the client. The Company adjusts its rebates payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. Any cumulative effect of these adjustments is recorded against revenues at the time it is identified. Adjustments generally result from contract changes with clients or manufacturers that have

retroactive rebate adjustments, differences between the estimated and actual product mix subject to rebates, or whether the brand name drug was included in the applicable formulary. The effect of adjustments

between estimated and actual manufacturers' rebate amounts has not been material to the Company's operating results or financial condition.

Guarantees

The Company also adjusts revenues for refunds owed to clients resulting from pricing guarantees and performance against defined service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Retail/LTC Segment

Retail Pharmacy

The Company's retail drugstores recognize revenue at the time the customer takes possession of the merchandise. For pharmacy sales, each prescription claim is its own arrangement with the customer and is a performance obligation, separate and distinct from other prescription claims under other retail network arrangements. Revenues are adjusted for refunds owed to third party payers resulting from pricing guarantees and performance against defined value-based service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Revenue from Company gift cards purchased by customers is deferred as a contract liability until goods or services are transferred. Any amounts not expected to be redeemed by customers (i.e., breakage) are recognized based on historical redemption patterns.

Customer returns are not material to the Company's operating results or financial condition. Sales taxes are not included in revenues.

Loyalty and Other Programs

The Company's customer loyalty program, ExtraCare®, consists of two components, ExtraSavings™ and ExtraBucks® Rewards. ExtraSavings are coupons that are recorded as a reduction of revenue when redeemed as the Company concluded that they do not represent a promise to the customer to deliver additional goods or services at the time of issuance because they are not tied to a specific transaction or spending level.

ExtraBucks Rewards are accumulated by customers based on their historical spending levels. Thus, the Company has determined that there is an additional performance obligation to those customers at the time of the initial transaction. The Company allocates the transaction price to the initial transaction and the ExtraBucks Rewards transaction based upon the relative standalone selling price, which considers historical redemption patterns for the rewards. Revenue allocated to ExtraBucks Rewards is recognized as those rewards are redeemed. At the end of each period, unredeemed ExtraBucks Rewards are reflected as a contract liability.

The Company also offers a subscription-based membership program, CarePass®, under which members are entitled to a suite of benefits delivered over the course of the subscription period, as well as a promotional reward that can be redeemed for future goods and services. Subscriptions are paid for on a monthly or annual basis at the time of or in advance of the Company delivering the goods and services. Revenue from these arrangements is recognized as the performance obligations are satisfied.

Long-term Care

Revenue is recognized when control of the promised goods or services is transferred to customers in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those goods or services. Each prescription claim represents a separate performance obligation of the Company, separate and distinct from other prescription claims under customer arrangements. A significant portion of Long-term Care revenue from sales of pharmaceutical and medical products is reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. The Company monitors its revenues and receivables from these reimbursement sources, as well as long-term care facilities and other third party insurance payors, and reduces revenue at the revenue recognition date to properly account for the variable consideration due to anticipated differences between billed and reimbursed amounts. Accordingly, the total revenues and receivables reported in the Company's consolidated financial statements are recorded at the amount expected to be ultimately received from these payors.

Patient co-payments associated with Medicare Part D, certain state Medicaid programs, Medicare Part B and certain third party payors typically are not collected at the time products are delivered or services are rendered, but are billed

to the individuals as part of normal billing procedures and subject to normal accounts receivable collections procedures.

Walk-In Medical Clinics
For services provided by the Company's walk-in medical clinics, revenue recognition occurs for completed services provided to patients, with adjustments taken for third party payor contractual obligations and patient direct bill historical collection rates.

Health Care Benefits Segment
Health Care Benefits revenue is principally derived from insurance premiums and fees billed to customers. Revenue is recognized based on customer billings, which reflect contracted rates per employee and the number of covered employees recorded in the Company's records at the time the billings are prepared. Billings are generally sent monthly for coverage during the following month.

The Company's billings may be subsequently adjusted to reflect enrollment changes due to member terminations or other factors. These adjustments are known as retroactivity adjustments. In each period, the Company estimates the amount of future retroactivity and adjusts the recorded revenue accordingly. As information regarding actual retroactivity amounts becomes known, the Company refines its estimates and records any required adjustments to revenues in the period in which they arise.

Premium Revenue
Premiums are recognized as revenue in the month in which the enrollee is entitled to receive health care services. Premiums are reported net of an allowance for estimated terminations and uncollectible amounts. Additionally, premium revenue subject to the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010's (as amended, collectively, the "ACA's") minimum medical loss ratio ("MLR") rebate requirements is recorded net of the estimated minimum MLR rebates for the current calendar year. Premiums related to unexpired contractual coverage periods (unearned premiums) are reported as other insurance liabilities on the consolidated balance sheets and recognized as revenue when earned.

Some of the Company's contracts allow for premiums to be adjusted to reflect actual experience or the relative health status of Insured members. Such adjustments are reasonably estimable at the outset of the contract, and adjustments to those estimates are made based on actual experience of the customer emerging under the contract and the terms of the underlying contract.

Services Revenue
Services revenue relates to contracts that can include various combinations of services or series of services which generally are capable of being distinct and accounted for as separate performance obligations. The Health Care Benefits segment's services revenue primarily consists of the following components:

- ASC fees are received in exchange for performing certain claim processing and member services for ASC members. ASC fee revenue is recognized over the period the service is provided. Some of the Company's administrative services contracts include guarantees with respect to certain functions, such as customer service response time, claim processing accuracy and claim processing turnaround time, as well as certain guarantees that a plan sponsor's benefit claim experience will fall within a certain range. With any of these guarantees, the Company is financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk typically is limited to a percentage of the fees otherwise payable to the Company by the customer involved. Each period the Company estimates its obligations under the terms of these guarantees and records its estimate as an offset to services revenues.
- Workers' compensation administrative services consist of fee-based managed care services. Workers' compensation administrative services revenue is recognized once the service is provided.

Accounting for Medicare Part D
Revenues include insurance premiums earned by the Company's PDPs, which are determined based on the PDP's annual bid and related contractual arrangements with the U.S. Centers for Medicare & Medicaid Services ("CMS"). The insurance premiums include a beneficiary premium, which is the responsibility of the PDP member, and can be subsidized by CMS in the case of low-income members, and a direct premium paid by CMS. Premiums collected in advance are initially recorded within other insurance liabilities and are then recognized ratably as revenue over the period in which members are entitled to receive benefits.

Revenues also include a risk-sharing feature of the Medicare Part D program design referred to as the risk corridor. The Company estimates variable consideration in the form of amounts payable to, or receivable from, CMS under the

risk corridor, and adjusts revenue based on calculations of additional subsidies to be received from or owed to CMS at the end of the reporting year.

In addition to Medicare Part D premiums, the Company receives additional payments each month from CMS related to catastrophic reinsurance, low-income cost sharing subsidies and coverage gap benefits. If the subsidies received differ from the

amounts earned from actual prescriptions transferred, the difference is recorded in either accounts receivable, net or accrued expenses.

Disaggregation of Revenue
The following table disaggregates the Company's revenue by major source in each segment for the years ended December 31, 2019 and 2018:

In millions	**Pharmacy Services**	**Retail/ LTC**	**Health Care Benefits**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
2019						
Major goods/services lines:						
Pharmacy	$ 140,896	$ 66,442	$ —	$ —	$ (41,439)	$ 165,899
Front Store	—	19,422	—	—	—	19,422
Premiums	—	—	63,031	91	—	63,122
Net investment income	—	—	599	412	—	1,011
Other	595	744	5,974	9	—	7,322
Total	$ 141,491	$ 86,608	$ 69,604	$ 512	$ (41,439)	$ 256,776
Pharmacy Services distribution channel:						
Pharmacy network (1)	$ 88,755					
Mail choice (2)	52,141					
Other	595					
Total	$ 141,491					
2018						
Major goods/services lines:						
Pharmacy	$ 134,216	$ 64,179	$ 164	$ —	$ (33,714)	$ 164,845
Front Store	—	19,055	—	—	—	19,055
Premiums	—	—	8,180	4	—	8,184
Net investment income	—	—	58	602	—	660
Other	520	755	560	—	—	1,835
Total	$ 134,736	$ 83,989	$ 8,962	$ 606	$ (33,714)	$ 194,579
Pharmacy Services distribution channel:						
Pharmacy network (1) (3)	$ 87,167					
Mail choice (2) (3)	47,049					
Other	520					
Total	$ 134,736					

(1) Pharmacy Services pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including the Company's retail pharmacies and LTC pharmacies, but excluding Maintenance Choice® activity, which is included within the mail choice category. Maintenance choice permits eligible client plan members to fill their maintenance prescriptions through mail order delivery or at a CVS pharmacy retail store for the same price as mail order.

(2) Pharmacy Services mail choice is defined as claims filled at a Pharmacy Services mail order facility, which includes specialty mail claims inclusive of Specialty Connect® claims picked up at a retail pharmacy, as well as prescriptions filled at the Company's retail pharmacies under the Maintenance Choice program.

(3) Certain prior year amounts have been reclassified for consistency with the current period presentation.

Contract Balances

Contract liabilities primarily represent the Company's obligation to transfer additional goods or services to a customer for which the Company has received consideration, and include ExtraBucks Rewards and unredeemed Company gift cards. The consideration received remains a contract liability until goods or services have been provided to the customer. In addition, the Company recognizes breakage on Company gift cards based on historical redemption patterns.

The following table provides information about receivables and contract liabilities from contracts with customers as of December 31, 2019 and 2018:

In millions	**2019**	**2018**
Trade receivables (included in accounts receivable, net)	$ 6,717	$ 6,497
Contract liabilities (included in accrued expenses)	73	67

During the year ended December 31, 2019, the contract liabilities balance includes increases related to customers' earnings in ExtraBucks Rewards or issuances of Company gift cards and decreases for revenues recognized during the period as a result of the redemption of ExtraBucks Rewards or Company gift cards and breakage of Company gift cards. Below is a summary of such changes:

In millions	**2019**	**2018**
Balance at December 31, 2018	$ 67	$ 53
Adoption of ASU 2014-09	—	17
Rewards earnings and gift card issuances	365	332
Redemption and breakage	(359)	(335)
Balance at December 31, 2019	$ 73	$ 67

Cost of Products Sold

The Company accounts for cost of products sold as follows:

Pharmacy Services Segment
Cost of products sold includes: (i) the cost of prescription drugs sold during the reporting period directly through the Company's mail service dispensing pharmacies and indirectly through the Company's retail pharmacy network, (ii) shipping and handling costs, and (iii) the operating costs of the Company's mail service dispensing pharmacies and client service operations and related information technology support costs including depreciation and amortization. The cost of prescription drugs sold component of cost of products sold includes: (i) the cost of the prescription drugs purchased from manufacturers or distributors and shipped to members in clients' benefit plans from the Company's mail service dispensing pharmacies, net of any volume-related or other discounts (see "Vendor Allowances and Purchase Discounts" below) and (ii) the cost of prescription drugs sold (including retail co-payments) through the Company's retail pharmacy network under contracts where the Company is the principal, net of any volume-related or other discounts.

Retail/LTC Segment
Cost of products sold includes: the cost of merchandise sold during the reporting period, including prescription drug costs, and the related purchasing costs, warehousing and delivery costs (including depreciation and amortization) and actual and estimated inventory losses.

Vendor Allowances and Purchase Discounts

The Company accounts for vendor allowances and purchase discounts as follows:

Pharmacy Services Segment
The Pharmacy Services segment receives purchase discounts on products purchased. Contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for the Pharmacy Services segment to receive purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These rebates are recognized when prescriptions are dispensed and are generally calculated and billed to manufacturers within 30 days of the end of each completed quarter. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material to the Company's operating results or financial condition. The Company accounts for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. The Pharmacy Services segment also receives additional discounts under its wholesaler contracts if it exceeds contractually defined purchase volumes. In addition, the Pharmacy Services segment receives fees from pharmaceutical

manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of cost of products sold.

Retail/LTC Segment
Vendor allowances received by the Retail/LTC segment reduce the carrying cost of inventory and are recognized in cost of products sold when the related inventory is sold, unless they are specifically identified as a reimbursement of incremental costs for promotional programs and/or other services provided. Amounts that are directly linked to advertising commitments are recognized as a reduction of advertising expense (included in operating expenses) when the related advertising commitment is satisfied. Any such allowances received in excess of the actual cost incurred also reduce the carrying cost of inventory. The total value of any upfront payments received from vendors that are linked to purchase commitments is initially deferred. The deferred amounts are then amortized to reduce cost of products sold over the life of the contract based upon purchase volume. The total value of any upfront payments received from vendors that are not linked to purchase commitments is also initially deferred. The deferred amounts are then amortized to reduce cost of products sold on a straight-line basis over the life of the related contract. The total amortization of these upfront payments was not material to the Company's consolidated financial statements in any of the periods presented.

Health Care Reform

Health Insurer Fee
Since January 1, 2014, the ACA imposes an annual premium-based health insurer fee ("HIF") for each calendar year payable in September which is not deductible for tax purposes. The Company is required to estimate a liability for the HIF at the beginning of the calendar year in which the fee is payable with a corresponding deferred asset that is amortized ratably to operating expenses over the calendar year. The Company records the liability for the HIF in accrued expenses and records the deferred asset in other current assets. There was no expense related to the HIF in 2019 and 2017, since the HIF was temporarily suspended for each of those periods. In 2018, operating expenses included $157 million related to the Company's share of the HIF. The HIF applies for 2020, and in December 2019, the HIF was repealed for calendar years after 2020.

Risk Adjustment
The ACA established a permanent risk adjustment program to transfer funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of the Company's qualified plan members relative to the average risk of members of other qualified plans in comparable markets, as defined by the ACA, the Company estimates its ultimate risk adjustment receivable (recorded in accounts receivable) or payable (recorded in accrued expenses) for the current calendar year and reflects the pro-rata year-to-date impact as an adjustment to premium revenue.

Advertising Costs

Advertising costs, which are reduced by the portion funded by vendors, are expensed when the related advertising takes place. Net advertising costs, which are included in operating expenses, were $396 million, $364 million and $230 million in 2019, 2018 and 2017, respectively.

Stock-Based Compensation

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as an expense over the applicable requisite service period of the stock award (generally 3 to 5 years) using the straight-line method.

Income Taxes

The Company accounts for income taxes under the asset and liability method, which requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of events that have been included in the consolidated financial statements. Under this method, deferred tax assets and liabilities are determined on the basis of the differences between the consolidated financial statements and tax basis of assets and liabilities using enacted tax rates in effect for the year or years in which the differences are expected to reverse. The effect of a change in the tax rates on deferred tax assets and liabilities is recognized in income in the period that includes the enactment date of such change.

The Tax Cuts and Jobs Act (the “TCJA”) was enacted on December 22, 2017. Among numerous changes to existing tax laws, the TCJA permanently reduced the federal corporate income tax rate from 35% to 21% effective January 1, 2018. The effects of changes in tax rates on deferred tax balances are required to be taken into consideration in the period in which the changes are

enacted, regardless of when they are effective. As a result of the reduction of the corporate income tax rate under the TCJA, the Company estimated the revaluation of its net deferred tax liabilities and recorded a provisional income tax benefit of approximately $1.5 billion for year ended December 31, 2017. In 2018, the Company completed its process of determining the TCJA's final impact and recorded an additional income tax benefit of $100 million.

The Company recognizes deferred tax assets to the extent that it believes these assets are more likely than not to be realized. In making such a determination, the Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax planning strategies, and the Company's recent operating results. The Company establishes a valuation allowance when it does not consider it more likely than not that a deferred tax asset will be recovered.

The Company records uncertain tax positions on the basis of a two-step process whereby (1) the Company determines whether it is more likely than not that the tax positions will be sustained on the basis of the technical merits of the position and (2) for those tax positions that meet the more-likely-than-not recognition threshold, the Company recognizes the largest amount of tax benefit that is more than 50% likely to be realized upon ultimate settlement with the related tax authority.

Interest and/or penalties related to uncertain tax positions are recognized in the income tax provision.

Measurement of Defined Benefit Pension and Other Postretirement Employee Benefit Plans

The Company sponsors defined benefit pension plans ("pension plans") and other postretirement employee benefit plans ("OPEB plans") for its employees and retirees. The Company recognizes the funded status of its pension and OPEB plans on the consolidated balance sheets based on the year-end measurements of plan assets and benefit obligations. When the fair value of plan assets are in excess of the plan benefit obligations, the amounts are reported in other current assets and other assets. When the fair value of plan benefit obligations are in excess of plan assets, the amounts are reported in accrued expenses and other long-term liabilities based on the amount by which the actuarial present value of benefits payable in the next twelve months included in the benefit obligation exceeds the fair value of plan assets. The net periodic benefit costs for the Company's pension and OPEB plans do not contain a service cost component as these plans have been frozen for an extended period of time. Non-service cost components of pension and postretirement benefit cost are included in other expense (income) in the consolidated statements of operations.

Earnings (Loss) per Common Share

Earnings (loss) per share is computed using the two-class method. The Company calculates basic earnings (loss) per share based on the weighted average number of common shares outstanding for the period. See Note 14 ‘‘Earnings (Loss) Per Share’’ for additional information.

Shares Held in Trust

The Company maintains grantor trusts, which held approximately one million shares of its common stock at both December 31, 2019 and 2018. These shares are designated for use under various employee compensation plans. Since the Company holds these shares, they are excluded from the computation of basic and diluted shares outstanding.

Variable Interest Entities

The Company has investments in (i) a generic pharmaceutical sourcing entity, (ii) certain hedge fund and private equity investments and (iii) certain real estate partnerships that are considered VIE's. The Company does not have a future obligation to fund losses or debts on behalf of these investments; however, it may voluntarily contribute funds. In evaluating whether the Company is the primary beneficiary of a VIE, the Company considers several factors, including whether the Company has (a) the power to direct the activities that most significantly impact the VIE's economic performance and (b) the obligation to absorb losses and the right to receive benefits that could potentially be significant to the VIE.

Variable Interest Entities - Primary Beneficiary
In 2014, the Company and Cardinal Health, Inc. ("Cardinal") established Red Oak Sourcing, LLC ("Red Oak"), a generic pharmaceutical sourcing entity in which the Company and Cardinal each own 50%. The Red Oak

arrangement has an initial term of 10 years. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak; however, Red Oak does not own or hold inventory on behalf of either company. No physical assets (e.g., property and

equipment) were contributed to Red Oak by either company, and minimal funding was provided to capitalize Red Oak. The Company has determined that it is the primary beneficiary of this VIE because it has the ability to direct the activities of Red Oak. Consequently, the Company consolidates Red Oak in its consolidated financial statements within the Retail/LTC segment.

Cardinal is required to pay the Company 39 quarterly payments beginning in October 2014. As milestones are met, the quarterly payments increase. The Company received from Cardinal $183 million during each of the years ended December 31, 2019, 2018 and 2017. The payments reduce the Company's carrying value of inventory and are recognized in cost of products sold when the related inventory is sold. Revenues associated with Red Oak expenses reimbursed by Cardinal for the years ended December 31, 2019, 2018 and 2017, and amounts due to or due from Cardinal at December 31, 2019 and 2018 were immaterial.

Variable Interest Entities - Other Variable Interest Holder
The Company has invested in certain VIEs for which it has determined that it is not the primary beneficiary, consisting of the following:

- *Hedge fund and private equity investments* - The Company invests in hedge fund and private equity investments in order to generate investment returns for its investment portfolio supporting its insurance businesses.

- *Real estate partnerships* - The Company invests in various real estate partnerships, including those that construct, own and manage low-income housing developments. For the low income housing development investments, substantially all of the projected benefits to the Company are from tax credits and other tax benefits.

The Company is not the primary beneficiary of these VIEs because the nature of the Company's involvement with the activities of these VIEs does not give the Company the power to direct the activities that most significantly impact their economic performance. The Company records the amount of its investment in these VIEs as long-term investments on the consolidated balance sheets and recognizes its share of each VIE's income or losses in net income (loss). The Company's maximum exposure to loss from these VIEs is limited to its investment balances as disclosed below and the risk of recapture of previously recognized tax credits related to the real estate partnerships, which the Company does not consider significant.

The total amount of other variable interest holder VIE assets included in long-term investments on the consolidated balance sheets at December 31, 2019 and 2018 was as follows:

In millions	**2019**	**2018**
Hedge fund investments	$ 271	$ 270
Private equity investments	538	524
Real estate partnerships	212	275
Total	$ 1,021	$ 1,069

Related Party Transactions

The Company has an equity method investment in SureScripts, LLC ("SureScripts"), which operates a clinical health information network. The Company utilizes this clinical health information network in providing services to its client plan members and retail customers. The Company expensed fees for the use of this network of $32 million, $45 million and $35 million in the years ended December 31, 2019, 2018 and 2017, respectively. The Company's investment in and equity in the earnings of SureScripts for all periods presented is immaterial.

The Company has an equity method investment in Heartland Healthcare Services ("Heartland"). Heartland operates several LTC pharmacies in four states. Heartland paid the Company $96 million, $135 million and $139 million for pharmaceutical inventory purchases during the years ended December 31, 2019, 2018 and 2017, respectively. Additionally, the Company performs certain collection functions for Heartland and then passes those customer cash collections back to Heartland. The Company's investment in and equity in the earnings of Heartland for all periods presented is immaterial.

During the year ended December 31, 2019, the Company made a charitable contribution of $30 million to the CVS Health Foundation, a non-profit entity that focuses on health, education and community involvement programs. The charitable contribution will fund future charitable giving and was recorded as an operating expense in the consolidated statement of operations for the year ended December 31, 2019.

Discontinued Operations

In connection with certain business dispositions completed between 1995 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Linens ‘n Things and Bob’s Stores, each of which subsequently filed for bankruptcy. The Company’s loss from discontinued operations primarily includes lease-related costs that the Company believes it will likely be required to satisfy pursuant to its Linens ‘n Things and Bob’s Stores lease guarantees. See “Lease Guarantees” in Note 16 ‘‘Commitments and Contingencies’’ for more information.

Results from discontinued operations were immaterial for the years ended December 31, 2019 and 2018. Below is a summary of the results of discontinued operations for the year ended December 31, 2017:

In millions	**2017**
Loss from discontinued operations	$ (13)
Income tax benefit	5
Loss from discontinued operations, net of tax	$ (8)

New Accounting Pronouncements Recently Adopted

Leases
In February 2016, the Financial Accounting Standards Board (the “FASB”) issued ASU 2016-02, *Leases* (Topic 842). Under this accounting standard, lessees are required to recognize a right-of-use asset and a lease liability for virtually all of their leases (other than leases that meet the definition of a short-term lease). The liability is equal to the present value of lease payments. The asset is based on the liability, subject to certain adjustments, such as for initial direct costs. For income statement purposes, a dual model was retained, requiring leases to be classified as either operating or finance leases. Operating leases result in straight-line expense (similar to operating leases under the prior accounting standard), while finance leases result in a front-loaded expense pattern (similar to capital leases under the prior accounting standard). Lessor accounting is similar to the prior model, but updated to align with certain changes to the lessee model (e.g., certain definitions, such as initial direct costs, have been updated) and the new revenue recognition standard that was adopted in 2018.

The Company adopted this new accounting standard on January 1, 2019 on a modified retrospective basis and applied the new standard to all leases through a cumulative-effect adjustment to beginning retained earnings. As a result, comparative financial information has not been restated and continues to be reported under the accounting standards in effect for those periods. The Company elected the package of practical expedients permitted under the transition guidance within the new standard, which includes, among other things, the ability to carry forward the existing lease classification. On January 1, 2019, the Company recorded an after-tax transition adjustment to increase retained earnings by approximately $178 million ($241 million prior to tax effect). The new standard had a material impact on the Company’s consolidated balance sheet, but did not materially impact the Company’s consolidated operating results and had no impact on the Company’s cash flows.

Impact of New Lease Standard on Balance Sheet Line Items
As a result of applying the new lease accounting standard using a modified retrospective method, the following adjustments were made to accounts on the consolidated balance sheet as of January 1, 2019:

		Impact of Change in Accounting Policy	
In millions	**As Reported December 31, 2018**	**Adjustments**	**As Adjusted January 1, 2019**
Consolidated Balance Sheets:			
Other current assets	$ 4,581	$ (48)	$ 4,533
Total current assets	45,243	(48)	45,195
Property and equipment, net	11,349	11	11,360
Operating lease right-of-use assets	—	20,987	20,987
Intangible assets, net	36,524	(217)	36,307
Other assets	5,046	(521)	4,525
Total assets	196,456	20,212	216,668
Accrued expenses	10,711	(52)	10,659
Current portion of operating lease liabilities	—	1,803	1,803
Current portion of long-term debt	1,265	2	1,267
Total current liabilities	44,009	1,753	45,762
Long-term operating lease liabilities	—	18,832	18,832
Long-term debt	71,444	(96)	71,348
Deferred income taxes	7,677	63	7,740
Other long-term liabilities	2,780	(518)	2,262
Total liabilities	137,913	20,034	157,947
Retained earnings	40,911	178	41,089
Total CVS Health shareholders' equity	58,225	178	58,403
Total shareholders' equity	58,543	178	58,721

Accounting for Interest Associated with the Purchase of Callable Debt Securities
In March 2017, the FASB issued ASU 2017-08, *Accounting for Interest Associated with the Purchase of Callable Debt Securities* (Topic 310). Under this standard, premiums on callable debt securities are amortized to the earliest call date rather than to the contractual maturity date. Callable debt securities held at a discount will continue to be amortized to the contractual maturity date. The Company adopted this new accounting standard on January 1, 2019 on a modified retrospective basis and recorded an immaterial cumulative effect adjustment from accumulated other comprehensive income to retained earnings on the consolidated balance sheet.

New Accounting Pronouncements Not Yet Adopted

Measurement of Credit Losses on Financial Instruments
In June 2016, the FASB issued ASU 2016-13, *Financial Instruments - Credit Losses* (Topic 326). This standard requires the use of a forward-looking expected credit loss impairment model for trade and other receivables, held-to-maturity debt securities, loans and other instruments. This standard also requires impairments and recoveries for available-for-sale debt securities to be recorded through an allowance account and revises certain disclosure requirements. The Company adopted this new accounting standard on January 1, 2020. The Company adopted the credit loss impairment model on a modified retrospective basis and recorded an immaterial cumulative effect adjustment to retained earnings as of the adoption date. The Company adopted the available-for-sale debt security impairment model on a prospective basis. The adoption of this standard did not have a material impact on the Company's consolidated operating results, cash flows or financial condition.

Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract
In August 2018, the FASB issued ASU 2018-15, *Intangibles - Goodwill and other - Internal-Use Software* (Topic 350-40): *Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract.* This standard requires a customer in a cloud computing arrangement that is a service contract to

follow the internal-use software guidance in Topic 350-40 to determine which implementation costs to capitalize as assets. The Company adopted this new

accounting guidance on January 1, 2020 on a prospective basis. The implementation of this standard is not expected to have a material impact on the Company's consolidated operating results, cash flows, financial condition or related disclosures.

Targeted Improvements to the Accounting for Long-Duration Insurance Contracts
In August 2018, the FASB issued ASU 2018-12, *Targeted Improvements to the Accounting for Long-Duration Contracts* (Topic 944). This standard requires the Company to review cash flow assumptions for its long-duration insurance contracts at least annually and recognize the effect of changes in future cash flow assumptions in net income (loss). This standard also requires the Company to update discount rate assumptions quarterly and recognize the effect of changes in these assumptions in other comprehensive income. The rate used to discount the Company's liability for future policy benefits will be based on an estimate of the yield for an upper-medium grade fixed-income instrument with a duration profile matching that of the Company's liabilities. In addition, this standard changes the amortization method for deferred acquisition costs and requires additional disclosures regarding the long duration insurance contract liabilities in the Company's interim and annual financial statements. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2021. The Company is currently evaluating the effect that implementation of this standard will have on the Company's consolidated operating results, cash flows, financial condition and related disclosures.

Simplifying the Accounting for Income Taxes
In December 2019, the FASB issued ASU 2019-12, *Simplifying the Accounting for Income Taxes* (Topic 740). This standard simplifies the accounting for income taxes by eliminating certain exceptions to the guidance in Accounting Standards Codification ("ASC") 740 related to the approach for intraperiod tax allocation, the methodology for calculating income taxes in an interim period and the recognition of deferred tax liabilities for outside basis differences. The standard also simplifies aspects of the accounting for franchise taxes and enacted changes in tax laws or rates and clarifies the accounting for transactions that result in a step-up in the tax basis of goodwill. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2021. Early adoption is permitted. The Company is currently evaluating the effect that implementation of this standard will have on the Company's consolidated operating results, cash flows, financial condition and related disclosures.

2. Acquisitions and Divestitures

Acquisition of Aetna

On the Aetna Acquisition Date, the Company acquired 100% of the outstanding shares and voting interests of Aetna for a combination of cash and stock. Under the terms of the merger agreement, Aetna shareholders received $145.00 in cash and 0.8378 CVS Health shares for each Aetna share. The transaction valued Aetna at approximately $212 per share or approximately $70 billion. Including the assumption of Aetna's debt, the total value of the transaction was approximately $78 billion. The Company financed the cash portion of the purchase price through a combination of cash on hand and by issuing approximately $45 billion of new debt, including senior notes and term loans. The Company acquired Aetna to help improve the consumer health care experience by combining Aetna's health care benefits products and services with CVS Health's approximately 9,900 retail locations, approximately 1,100 walk-in medical clinics and integrated pharmacy capabilities with the goal of becoming the new, trusted front door to health care.

The transaction has been accounted for using the acquisition method of accounting which requires, among other things, the assets acquired and liabilities assumed to be recognized at their fair values at the date of acquisition. The following table summarizes the fair values of the assets acquired and liabilities assumed at the date of acquisition:

In millions	
Cash and cash equivalents	$ 6,565
Accounts receivable	4,094
Other current assets	3,894
Investments (current and long-term)	17,984
Goodwill	47,755
Intangible assets	22,571
Other assets	8,249
Total assets acquired	111,112
Health care costs payable	5,302
Other current liabilities	9,940
Debt (current and long-term)	8,098
Deferred income taxes	4,608
Other long-term liabilities	13,078
Total liabilities assumed	41,026
Noncontrolling interests	320
Total consideration transferred	$ 69,766

The Company's assessment of the fair value of assets acquired and liabilities assumed was finalized during the fourth quarter of 2019. Measurement period adjustments to assets acquired and liabilities assumed during the year ended December 31, 2019 primarily were due to additional information received related to certain intangible asset valuations and contingencies and the related impact on the accounting for income taxes and goodwill. There were no material income statement measurement period adjustments recorded during the year ended December 31, 2019.

Consolidated Results of Operations
The Company's consolidated operating results for the year ended December 31, 2018, included $5.6 billion of revenues and $146 million of income before income tax provision associated with the operating results of Aetna from the Aetna Acquisition Date to December 31, 2018.

During the years ended December 31, 2018 and 2017, the Company incurred transaction costs of $147 million and $34 million, respectively, associated with the Aetna Acquisition that were recorded within operating expenses.

Unaudited Pro Forma Financial Information

The following unaudited pro forma information presents a summary of the Company's combined operating results for the years ended December 31, 2018 and 2017 as if the Aetna acquisition and the related financing transactions had occurred on January 1, 2017. The following pro forma financial information is not necessarily indicative of the Company's operating results as they

would have been had the acquisition been effected on the assumed date, nor is it necessarily an indication of trends in future results for a number of reasons, including differences between the assumptions used to prepare the pro forma financial information, basic shares outstanding and dilutive equivalents, cost savings from operating efficiencies, potential synergies, and the impact of incremental costs incurred in integrating the businesses.

	Year Ended December 31,	
In millions, except per share data	**2018**	**2017**
Total revenues	$ 243,232	$ 236,000
Income from continuing operations	1,152	6,813
Basic earnings per share from continuing operations attributable to CVS Health	$ 0.89	$ 5.25
Diluted earnings per share from continuing operations attributable to CVS Health	$ 0.88	$ 5.21

The pro forma results for the years ended December 31, 2018 and 2017 include adjustments related to the following purchase accounting and acquisition-related items:

- Elimination of intercompany transactions between CVS Health and Aetna;
- Elimination of estimated foregone interest income associated with (i) cash assumed to have been used to partially fund the Aetna Acquisition and (ii) adjusting the amortized cost of Aetna's investment portfolio to fair value as of the completion of the Aetna Acquisition;
- Elimination of historical intangible asset, deferred acquisition cost and capitalized software amortization expense and addition of amortization expense based on the values of identified intangible assets;
- Additional interest expense from (i) the long-term debt issued to partially fund the Aetna Acquisition and (ii) the amortization of the fair value adjustment to assumed long-term debt.
- Additional depreciation expense related to the adjustment of Aetna's property and equipment to fair value;
- Adjustments to align CVS Health's and Aetna's accounting policies;
- Elimination of transaction related costs; and
- Tax effects of the adjustments noted above.

Divestiture of Brazilian Subsidiary

On July 1, 2019, the Company sold its Brazilian subsidiary, Onofre, for an immaterial amount. Onofre operated 50 retail pharmacy stores, the results of which historically had been reported within the Retail/LTC segment. The Company recorded a pre-tax loss on the divestiture of $205 million in the year ended December 31, 2019, which primarily relates to the elimination of the cumulative translation adjustment from accumulated other comprehensive income and is reflected in operating expenses in the Company's consolidated statements of operations within the Retail/LTC segment.

Divestiture of RxCrossroads Subsidiary

On January 2, 2018, the Company sold its RxCrossroads subsidiary, the results of which had historically been reported within the Retail/LTC segment, to McKesson Corporation for $725 million. The Company recorded a pre-tax loss on the divestiture of $86 million in the year ended December 31, 2018 and transaction costs associated with the sale of $9 million in the year ended December 31, 2017, each of which were reflected in operating expenses in the Company's consolidated statements of operations within the Retail/LTC segment.

3. Investments

Total investments at December 31, 2019 and 2018 were as follows:

	2019			2018		
In millions	**Current**	**Long-term**	**Total**	**Current**	**Long-term**	**Total**

Debt securities available for sale	$ 2,251	$ 14,671	$ 16,922	$ 2,359	$ 12,896	$ 15,255
Mortgage loans	122	1,091	1,213	145	1,216	1,361
Other investments	—	1,552	1,552	18	1,620	1,638
Total investments	$ 2,373	$ 17,314	$ 19,687	$ 2,522	$ 15,732	$ 18,254

At December 31, 2019 and 2018, the Company held investments of $537 million and $531 million, respectively, related to the 2012 conversion of an existing group annuity contract from a participating to a non-participating contract. The conversion occurred prior to the Aetna Acquisition. These investments are included in the total investments of large case pensions supporting non-experience-rated products. Although these investments are not accounted for as Separate Accounts assets, they are legally segregated and are not subject to claims that arise out of the Company's business and only support future policy benefits obligations under that group annuity contract.

Debt Securities

Debt securities available for sale at December 31, 2019 and 2018 were as follows:

In millions	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2019				
Debt securities:				
U.S. government securities	$ 1,791	$ 62	$ (1)	$ 1,852
States, municipalities and political subdivisions	2,202	108	(1)	2,309
U.S. corporate securities	7,167	573	(3)	7,737
Foreign securities	2,149	200	(1)	2,348
Residential mortgage-backed securities	508	25	—	533
Commercial mortgage-backed securities	654	46	—	700
Other asset-backed securities	1,397	13	(5)	1,405
Redeemable preferred securities	30	8	—	38
Total debt securities [1]	$ 15,898	$ 1,035	$ (11)	$ 16,922
December 31, 2018				
Debt securities:				
U.S. government securities	$ 1,662	$ 26	$ —	$ 1,688
States, municipalities and political subdivisions	2,370	30	(1)	2,399
U.S. corporate securities	6,444	61	(16)	6,489
Foreign securities	2,355	31	(3)	2,383
Residential mortgage-backed securities	567	10	—	577
Commercial mortgage-backed securities	594	11	—	605
Other asset-backed securities	1,097	3	(15)	1,085
Redeemable preferred securities	30	—	(1)	29
Total debt securities [1]	$ 15,119	$ 172	$ (36)	$ 15,255

(1) Investment risks associated with the Company's experience-rated products generally do not impact the Company's consolidated operating results. At December 31, 2019, debt securities with a fair value of $965 million, gross unrealized capital gains of $83 million and no gross unrealized capital losses, and at December 31, 2018, debt securities with a fair value of $916 million, gross unrealized capital gains of $12 million and gross unrealized capital losses of $2 million were included in total debt securities, but support experience-rated products. Changes in net unrealized capital gains (losses) on these securities are not reflected in accumulated other comprehensive income.

The amortized cost and fair value of debt securities at December 31, 2019 are shown below by contractual maturity. Actual maturities may differ from contractual maturities because securities may be restructured, called or prepaid, or the Company intends to sell a security prior to maturity.

In millions	**Amortized Cost**	**Fair Value**
Due to mature:		
Less than one year	$ 1,028	$ 1,034
One year through five years	5,507	5,702
After five years through ten years	3,081	3,296
Greater than ten years	3,723	4,252
Residential mortgage-backed securities	508	533
Commercial mortgage-backed securities	654	700
Other asset-backed securities	1,397	1,405
Total	$ 15,898	$ 16,922

Mortgage-Backed and Other Asset-Backed Securities
All of the Company's residential mortgage-backed securities at December 31, 2019 were issued by the Government National Mortgage Association, the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation and carry agency guarantees and explicit or implicit guarantees by the U.S. Government. At December 31, 2019, the Company's residential mortgage-backed securities had an average credit quality rating of AAA and a weighted average duration of 3.3 years.

The Company's commercial mortgage-backed securities have underlying loans that are dispersed throughout the United States. Significant market observable inputs used to value these securities include loss severity and probability of default. At December 31, 2019, these securities had an average credit quality rating of AAA and a weighted average duration of 6.1 years.

The Company's other asset-backed securities have a variety of underlying collateral (e.g., automobile loans, credit card receivables, home equity loans and commercial loans). Significant market observable inputs used to value these securities include the unemployment rate, loss severity and probability of default. At December 31, 2019, these securities had an average credit quality rating of AA and a weighted average duration of 1.2 years.

Summarized below are the debt securities the Company held at December 31, 2019 and 2018 that were in an unrealized capital loss position, aggregated by the length of time the investments have been in that position:

	Less than 12 months			Greater than 12 months			Total		
In millions, except number of securities	**Number of Securities**	**Fair Value**	**Unrealized Losses**	**Number of Securities**	**Fair Value**	**Unrealized Losses**	**Number of Securities**	**Fair Value**	**Unrealized Losses**
December 31, 2019									
Debt securities:									
U.S. government securities	52	$ 168	$ 1	—	$ —	$ —	52	$ 168	$ 1
States, municipalities and political subdivisions	66	115	1	2	5	—	68	120	1
U.S. corporate securities	181	305	2	2	—	1	183	305	3
Foreign securities	39	75	1	—	—	—	39	75	1
Residential mortgage-backed securities	30	16	—	9	—	—	39	16	—
Commercial mortgage-backed securities	16	49	—	—	—	—	16	49	—
Other asset-backed securities	138	254	1	187	182	4	325	436	5
Total debt securities	522	$ 982	$ 6	200	$ 187	$ 5	722	$ 1,169	$ 11
December 31, 2018									
Debt securities:									
U.S. government securities	8	$ 26	$ —	—	$ —	$ —	8	$ 26	$ —
States, municipalities and political subdivisions	54	86	1	—	—	—	54	86	1
U.S. corporate securities	1,399	1,431	16	—	—	—	1,399	1,431	16
Foreign securities	243	314	3	—	—	—	243	314	3
Residential mortgage-backed securities	45	1	—	—	—	—	45	1	—
Other asset-backed securities	516	528	15	—	—	—	516	528	15
Redeemable preferred securities	14	23	1	—	—	—	14	23	1
Total debt securities	2,279	$ 2,409	$ 36	—	$ —	$ —	2,279	$ 2,409	$ 36

The Company reviewed the securities in the tables above and concluded that they are performing assets generating investment income to support the needs of the Company's business. In performing this review, the Company considered factors such as the quality of the investment security based on research performed by the Company's internal credit analysts and external rating agencies and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. As of December 31, 2019, the Company did not intend to sell these securities, and did not believe it was more likely than not that it would be required to sell these securities prior to the anticipated recovery of their amortized cost basis. Since Aetna's investment portfolio was measured at

fair value as of the Aetna Acquisition Date, each of the securities as of December 31, 2018 were in an unrealized loss position for less than 12 months.

The maturity dates for debt securities in an unrealized capital loss position at December 31, 2019 were as follows:

	Supporting experience-rated products		Supporting remaining products		Total	
In millions	**Fair Value**	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**
Due to mature:						
Less than one year	$ —	$ —	$ 12	$ —	$ 12	$ —
One year through five years	3	—	285	1	288	1
After five years through ten years	9	—	151	2	160	2
Greater than ten years	11	—	197	3	208	3
Residential mortgage-backed securities	—	—	16	—	16	—
Commercial mortgage-backed securities	—	—	49	—	49	—
Other asset-backed securities	10	—	426	5	436	5
Total	$ 33	$ —	$ 1,136	$ 11	$ 1,169	$ 11

Mortgage Loans

The Company's mortgage loans are collateralized by commercial real estate. During 2019 and subsequent to the Aetna Acquisition Date in 2018, the Company had the following activity in its mortgage loan portfolio:

In millions	**2019**	**2018**
New mortgage loans	$ 131	$ 4
Mortgage loans fully-repaid	234	27
Mortgage loans foreclosed	—	—

The Company assesses mortgage loans on a regular basis for credit impairments, and annually assigns a credit quality indicator to each loan. The Company's credit quality indicator is internally developed and categorizes its portfolio on a scale from 1 to 7. These indicators are based upon several factors, including current loan-to-value ratios, property condition, market trends, creditworthiness of the borrower and deal structure.

- *Category 1* - Represents loans of superior quality.
- *Categories 2 to 4* - Represent loans where credit risk is minimal to acceptable; however, these loans may display some susceptibility to economic changes.
- *Categories 5 and 6* - Represent loans where credit risk is not substantial, but these loans warrant management's close attention.
- *Category 7* - Represents loans where collections are potentially at risk; if necessary, an impairment is recorded.

Based upon the Company's assessments at December 31, 2019 and 2018, the Company's mortgage loans were given the following credit quality indicators:

In millions, except credit ratings indicator	**2019**	**2018**
1	$ 58	$ 42
2 to 4	1,143	1,301
5 and 6	12	18
7	—	—
Total	$ 1,213	$ 1,361

At December 31, 2019 scheduled mortgage loan principal repayments were as follows:

In millions	
2020	$ 122
2021	235
2022	200
2023	81
2024	193
Thereafter	382
Total	$ 1,213

Net Investment Income

Sources of net investment income for the years ended December 31, 2019 and 2018 were as follows:

In millions	**2019**	**2018**
Debt securities	$ 589	$ 61
Mortgage loans	71	6
Other investments	194	593
Gross investment income	854	660
Investment expenses	(42)	(3)
Net investment income (excluding net realized capital gains or losses)	812	657
Net realized capital gains [1]	199	3
Net investment income [2]	$ 1,011	$ 660

(1) Net realized capital gains are net of other-than-temporary impairment ("OTTI") losses on debt securities recognized in the consolidated statements of operations of $24 million for the year ended December 31, 2019. There were no material OTTI losses on debt securities for the year ended December 31, 2018.

(2) Net investment income includes $44 million and $4 million for 2019 and 2018, respectively, related to investments supporting experience-rated products.

The Company's net investment income was $21 million in 2017, relating to interest income on cash equivalents and debt securities. The Company did not have any material realized capital gains or losses during 2017.

Capital gains and losses recognized during the year ended December 31, 2019 related to investments in equity securities held as of December 31, 2019 were not material.

Excluding amounts related to experience-rated products, proceeds from the sale of available for sale debt securities and the related gross realized capital gains and losses in the year ended December 31, 2019 and subsequent to the Aetna Acquisition Date in 2018 were as follows:

In millions	**2019**	**2018**
Proceeds from sales	$ 4,773	$ 389
Gross realized capital gains	146	2
Gross realized capital losses	(17)	(2)

4. Fair Value

The preparation of the Company's consolidated financial statements in accordance with GAAP requires certain assets and liabilities to be reflected at their fair value and others to be reflected on another basis, such as an adjusted historical cost basis. In this note, the Company provides details on the fair value of financial assets and liabilities and how it determines those fair values. The Company presents this information for those financial instruments that are

measured at fair value for which the change in fair value impacts net income (loss) attributable to CVS Health or other comprehensive income separately from other financial assets and liabilities.

Financial Instruments Measured at Fair Value on the Consolidated Balance Sheets

Certain of the Company's financial instruments are measured at fair value on the consolidated balance sheets. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by GAAP. The following are the levels of the hierarchy and a brief description of the type of valuation information ("valuation inputs") that qualifies a financial asset or liability for each level:

- Level 1 – Unadjusted quoted prices for identical assets or liabilities in active markets.
- Level 2 – Valuation inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, valuation inputs that are observable that are not prices (such as interest rates and credit risks) and valuation inputs that are derived from or corroborated by observable markets.
- Level 3 – Developed from unobservable data, reflecting the Company's assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, the Company uses these quoted market prices to determine the fair value of financial assets and liabilities and classifies these assets and liabilities in Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, the Company estimates fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities are classified in Level 2. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The following is a description of the valuation methodologies used for the Company's financial assets and liabilities that are measured at fair value, including the general classification of such assets and liabilities pursuant to the valuation hierarchy.

Cash and Cash Equivalents – The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. When quoted prices are available in an active market, cash equivalents are classified in Level 1 of the fair value hierarchy. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt Securities – Where quoted prices are available in an active market, debt securities are classified in Level 1 of the fair value hierarchy. The Company's Level 1 debt securities consist primarily of U.S. Treasury securities.

The fair values of the Company's Level 2 debt securities are obtained using models, such as matrix pricing, which use quoted market prices of debt securities with similar characteristics or discounted cash flows to estimate fair value. The Company reviews these prices to ensure they are based on observable market inputs that include quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets and inputs that are observable that are not prices (such as interest rates and credit risks). The Company also reviews the methodologies and the assumptions used to calculate prices from these observable inputs. On a quarterly basis, the Company selects a sample of its Level 2 debt securities' prices and compares them to prices provided by a secondary source. Variances over a specified threshold are identified and reviewed to confirm the price provided by the primary source represents an appropriate estimate of fair value. In addition, the Company's internal investment team consistently compares the prices obtained for select Level 2 debt securities to the team's own independent estimates of fair value for those securities. The Company obtained one price for each of its Level 2 debt securities and did not adjust any of those prices at December 31, 2019 or 2018.

The Company also values certain debt securities using Level 3 inputs. For Level 3 debt securities, fair values are determined by outside brokers or, in the case of certain private placement securities, are priced internally. Outside brokers determine the value of these debt securities through a combination of their knowledge of the current pricing environment and market flows. The Company did not have any broker quoted debt securities at December 31, 2019. The total fair value of broker quoted debt securities at

December 31, 2018 was $50 million. The Company obtained one non-binding broker quote for each of these Level 3 debt securities and did not adjust any of those quotes at December 31, 2018. Examples of these broker quoted Level 3 debt securities include certain U.S. and foreign corporate securities and certain of the Company's commercial mortgage-backed securities as well as other asset-backed securities. For some private placement securities, the Company's internal staff determines the value of these debt securities by analyzing spreads of corporate and sector indices as well as interest spreads of comparable public

bonds. Examples of these private placement Level 3 debt securities include certain U.S. and foreign securities and certain tax-exempt municipal securities.

Equity Securities – The Company currently has two classifications of equity securities: those that are publicly traded and those that are privately placed. Publicly-traded equity securities are classified in Level 1 because quoted prices are available for these securities in an active market. For privately placed equity securities, there is no active market; therefore, these securities are classified in Level 3 because the Company prices these securities through an internal analysis of each investment's financial statements and cash flow projections. Significant unobservable inputs consist of earnings and revenue multiples, discount for lack of marketability and comparability adjustments. An increase or decrease in any of these unobservable inputs would result in a change in the fair value measurement, which may be significant.

There were no financial liabilities measured at fair value on a recurring basis on the consolidated balance sheets at December 31, 2019 or 2018. Financial assets measured at fair value on a recurring basis on the consolidated balance sheets at December 31, 2019 and 2018 were as follows:

In millions	**Level 1**	**Level 2**	**Level 3**	**Total**
December 31, 2019				
Cash and cash equivalents	$ 3,397	$ 2,286	$ —	$ 5,683
Debt securities:				
U.S. government securities	1,785	67	—	1,852
States, municipalities and political subdivisions	—	2,309	—	2,309
U.S. corporate securities	—	7,700	37	7,737
Foreign securities	—	2,348	—	2,348
Residential mortgage-backed securities	—	533	—	533
Commercial mortgage-backed securities	—	700	—	700
Other asset-backed securities	—	1,405	—	1,405
Redeemable preferred securities	—	26	12	38
Total debt securities	1,785	15,088	49	16,922
Equity securities	34	—	39	73
Total	$ 5,216	$ 17,374	$ 88	$ 22,678
December 31, 2018				
Cash and cash equivalents	$ 2,619	$ 1,440	$ —	$ 4,059
Debt securities:				
U.S. government securities	1,597	91	—	1,688
States, municipalities and political subdivisions	—	2,399	—	2,399
U.S. corporate securities	—	6,422	67	6,489
Foreign securities	—	2,380	3	2,383
Residential mortgage-backed securities	—	577	—	577
Commercial mortgage-backed securities	—	605	—	605
Other asset-backed securities	—	1,085	—	1,085
Redeemable preferred securities	—	22	7	29
Total debt securities	1,597	13,581	77	15,255
Equity securities	19	—	54	73
Total	$ 4,235	$ 15,021	$ 131	$ 19,387

There were no transfers between Levels 1 and 2 during the years ended December 31, 2019 and 2018. The changes in the balances of Level 3 financial assets during 2019 were as follows:

In millions	Foreign securities	U.S. corporate securities	Equity securities	Redeemable preferred securities	Total
Beginning balance	$ 3	$ 67	$ 54	$ 7	$ 131
Net realized and unrealized capital gains (losses):					
Included in earnings	—	(33)	13	—	(20)
Included in other comprehensive income	—	18	—	5	23
Purchases	2	3	13	—	18
Sales	—	(6)	(41)	—	(47)
Settlements	(1)	(12)	—	—	(13)
Transfers out of Level 3, net	(4)	—	—	—	(4)
Ending balance	$ —	$ 37	$ 39	$ 12	$ 88

The total gross transfers into (out of) Level 3 during the year ended December 31, 2019 were as follows:

In millions	
Gross transfers into Level 3	$ —
Gross transfers out of Level 3	(4)
Net transfers out of Level 3	$ (4)

The increase in the balance of Level 3 financial assets during 2018 relates to investments acquired in the Aetna Acquisition, which occurred on November 28, 2018. There were no transfers into or out of Level 3 subsequent to the Aetna Acquisition Date in 2018.

Financial Instruments Not Measured at Fair Value on the Consolidated Balance Sheets

The carrying value and estimated fair value classified by level of fair value hierarchy for financial instruments carried on the consolidated balance sheets at adjusted cost or contract value at December 31, 2019 and 2018 were as follows:

	Carrying	Estimated Fair Value			
In millions	Value	Level 1	Level 2	Level 3	Total
December 31, 2019					
Assets:					
Mortgage loans	$ 1,213	$ —	$ —	$ 1,239	$ 1,239
Equity securities [1]	149	N/A	N/A	N/A	N/A
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	5	—	—	5	5
Without a fixed maturity	372	—	—	392	392
Long-term debt	68,480	74,306	—	—	74,306

In millions	Carrying Value	Estimated Fair Value			
		Level 1	Level 2	Level 3	Total
December 31, 2018					
Assets:					
Mortgage loans	$ 1,361	$ —	$ —	$ 1,366	$ 1,366
Equity securities (1)	140	N/A	N/A	N/A	N/A
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	5	—	—	5	5
Without a fixed maturity	382	—	—	357	357
Long-term debt	72,709	71,252	—	—	71,252

(1) It was not practical to estimate the fair value of these cost-method investments as it represents shares of unlisted companies. See Note 1 "Significant Accounting Policies" for additional information regarding the valuation of cost method investments.

Separate Accounts Measured at Fair Value on the Consolidated Balance Sheets

Separate Accounts assets relate to the Company's large case pensions products which represent funds maintained to meet specific objectives of contract holders. Since contract holders bear the investment risk of these assets, a corresponding Separate Accounts liability has been established equal to the assets. These assets and liabilities are carried at fair value. Net investment income and capital gains and losses on Separate Accounts assets accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from the Company's other businesses. Deposits, withdrawals, net investment income and realized and unrealized capital gains and losses on Separate Accounts assets are not reflected in the consolidated statements of operations, shareholders' equity or cash flows.

Separate Accounts assets include debt and equity securities. The valuation methodologies used for these assets are similar to the methodologies described above in this Note 4 "Fair Value." Separate Accounts assets also include investments in common/collective trusts that are carried at fair value. Common/collective trusts invest in other investment funds otherwise known as the underlying funds. The Separate Accounts' interests in the common/collective trust funds are based on the fair values of the investments of the underlying funds and therefore are classified in Level 2. The assets in the underlying funds primarily consist of equity securities. Investments in common/collective trust funds are valued at their respective net asset value ("NAV") per share/unit on the valuation date.

Separate Accounts financial assets at December 31, 2019 and 2018 were as follows:

	December 31, 2019				December 31, 2018			
In millions	Level 1	Level 2	Level 3	Total	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 2	$ 143	$ —	$ 145	$ 2	$ 189	$ —	$ 191
Debt securities	1,224	2,589	—	3,813	782	2,500	4	3,286
Equity securities	—	2	—	2	—	3	—	3
Common/collective trusts	—	499	—	499	—	404	—	404
Total	$ 1,226	$ 3,233	$ —	$ 4,459	$ 784	$ 3,096	$ 4	$ 3,884

During 2019 and 2018, there were no transfers of Separate Accounts financial assets between Levels 1 and 2. During 2019 and 2018, the Company had an immaterial amount of gross transfers of Separate Accounts financial assets into or out of Level 3.

Offsetting Financial Assets and Liabilities

Certain financial assets and liabilities are offset in the Company's consolidated balance sheets or are subject to master netting arrangements or similar agreements with the applicable counterparty. Financial liabilities subject to offsetting and enforceable master netting arrangements were $3 million as of December 31, 2019. Financial assets subject to offsetting and enforceable master netting arrangements were $13 million as of December 31, 2018.

5. Goodwill and Other Intangibles

Goodwill

Below is a summary of the changes in the carrying amount of goodwill by segment for the years ended December 31, 2019 and 2018:

In millions	Pharmacy Services	Retail/ LTC	Health Care Benefits	Total
Balance at December 31, 2017	$ 21,819	$ 16,632	$ —	$ 38,451
Acquisitions	1,569	735	44,484	46,788
Foreign currency translation adjustments	—	(14)	—	(14)
Divestiture of RxCrossroads subsidiary	—	(398)	—	(398)
Impairments	—	(6,149)	—	(6,149)
Balance at December 31, 2018	23,388	10,806	44,484	78,678
Segment realignment	194	—	(194)	—
Purchase accounting adjustments	—	—	1,071	1,071
Other	(1)	1	—	—
Balance at December 31, 2019	$ 23,581	$ 10,807	$ 45,361	$ 79,749

Cumulative goodwill impairments were $6.1 billion at both December 31, 2019 and 2018.

The changes in the carrying amount of goodwill during the years ended December 31, 2019 and 2018 reflect the following activity:

Segment Realignment
During 2019, the Company realigned the composition of its segments to correspond with changes to its operating model and reflect how the CODM reviews information and manages the business as discussed in Note 1 ‘‘Significant Accounting Policies.’’ As a result of this realignment, the Company reallocated the goodwill balance of the Pharmacy Services and Health Care Benefits segments based on a relative fair value approach.

Aetna Acquisition
On November 28, 2018, the Company completed the Aetna Acquisition. The majority of the preliminary valuation of goodwill associated with the Aetna Acquisition was recorded in the Health Care Benefits segment. The Company also allocated a portion of such goodwill to the Retail/LTC and Pharmacy Services segments related to the fair value of identified synergies that are expected to directly benefit those segments. During 2019, the Company finalized its purchase accounting assessment and recorded the applicable measurement period adjustments, including an adjustment to the acquired goodwill. See Note 2 ‘‘Acquisitions and Divestitures’’ for further discussion regarding the Aetna Acquisition.

LTC
During 2018, the LTC reporting unit continued to experience industry-wide challenges that impacted management’s ability to grow the business at the rate that was originally estimated when the Company acquired Omnicare, Inc. (“Omnicare”) and when the 2017 annual goodwill impairment test was performed. Those challenges include lower client retention rates, lower occupancy rates in skilled nursing facilities, the deteriorating financial health of numerous skilled nursing facility customers which resulted in a number of customer bankruptcies in 2018, and continued facility reimbursement pressures. In June 2018, LTC management submitted its initial budget for 2019 and updated the 2018 annual forecast which showed a deterioration in the projected financial results for the remainder of 2018 and in 2019, which also caused management to update its long-term forecast beyond 2019. Based on these updated projections, management determined that there were indicators that the LTC reporting unit’s goodwill may be impaired and, accordingly, management performed an interim goodwill impairment test as of June 30, 2018. The results of that interim impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in a $3.9 billion pre-tax goodwill impairment charge in the second quarter of 2018. The fair value of the LTC reporting unit was determined using a combination of a discounted cash flow method and a market multiple method. In addition to the lower financial projections, changes in risk-free interest rates and lower market multiples of peer group companies contributed to the amount of the 2018 goodwill impairment charges.

During the third quarter of 2018, the Company performed its required annual impairment tests of goodwill and concluded there was no impairment of goodwill or trade names.

During the fourth quarter of 2018, the LTC reporting unit missed its forecast primarily due to operational issues and customer liquidity issues, including one significant customer bankruptcy. Additionally, LTC management submitted an updated final budget for 2019 which showed significant additional deterioration in the projected financial results for 2019 compared to the analyses performed in the second and third quarters of 2018 primarily due to continued industry and operational challenges, which also caused management to make further updates to its long-term forecast beyond 2019. The updated projections reflected continued industry wide challenges including lower occupancy rates in skilled nursing facilities, significant deterioration in the financial health of numerous skilled nursing facility customers and continued facility reimbursement pressures. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be further impaired and, accordingly, management performed an interim goodwill impairment test during the fourth quarter of 2018. The results of that interim impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in an additional $2.2 billion pre-tax goodwill impairment charge in the fourth quarter of 2018. In addition to the lower financial projections, lower market multiples of peer group companies also contributed to the amount of the fourth quarter 2018 goodwill impairment charge. The fair value of the LTC reporting unit was determined using a methodology consistent with the methodology described above for the analyses performed during the second and third quarters of 2018.

During the third quarter of 2019, the Company performed its required annual impairment tests of goodwill. The results of these impairment tests indicated that there was no impairment of goodwill. As of December 31, 2019, the remaining goodwill balance in the LTC reporting unit was $431 million.

RxCrossroads

During 2017, the Company began pursuing various strategic alternatives for its RxCrossroads reporting unit. In connection with this effort, the Company performed an interim goodwill impairment test in the second quarter of 2017. The results of that impairment test showed that the fair value of the RxCrossroads reporting unit was lower than the carrying value, resulting in a $135 million pre-tax goodwill impairment charge in the second quarter of 2017.

The TCJA was enacted on December 22, 2017 and reduced the U.S. federal corporate income tax rate from 35% to 21% effective January 1, 2018 (see Note 10 ‘‘Income Taxes’’). As a result, the RxCrossroads deferred income tax liabilities were reduced by $47 million and an income tax benefit of $47 million was recorded in the 2017 statement of operations. The reduction in the deferred income tax liabilities increased the carrying value of the RxCrossroads reporting unit by $47 million which triggered an additional goodwill impairment charge in the RxCrossroads reporting unit of $46 million during the fourth quarter of 2017.

On January 2, 2018, the Company sold its RxCrossroads subsidiary to McKesson Corporation for $725 million, at which time the remaining goodwill of this reporting unit was removed from the consolidated balance sheets.

Intangible Assets

The following table is a summary of the Company's intangible assets as of December 31, 2019 and 2018:

In millions, except weighted average life	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Weighted Average Life (years)
2019				
Trademarks (indefinite-lived)	$ 10,498	$ —	$ 10,498	N/A
Customer contracts/relationships and covenants not to compete	25,447	(8,128)	17,319	14.8
Technology	1,060	(386)	674	3.0
Provider networks	4,200	(229)	3,971	20.0
Value of Business Acquired	590	(63)	527	20.0
Other	364	(232)	132	8.1
Total	$ 42,159	$ (9,038)	$ 33,121	15.1
2018				
Trademarks (indefinite-lived)	$ 10,498	$ —	$ 10,498	N/A
Customer contracts/relationships and covenants not to compete	26,213	(6,349)	19,864	14.8
Technology	1,060	(31)	1,029	3.0
Provider networks	4,200	(19)	4,181	20.0
Value of Business Acquired	590	(7)	583	20.0
Favorable leases and other [1]	1,177	(808)	369	17.1
Total	$ 43,738	$ (7,214)	$ 36,524	15.3

(1) Upon adoption of ASU 2016-02, *Leases*, the Company's favorable leases were reclassified from an intangible asset to a reduction of the right-of-use asset. Refer to Note 1 "Significant Accounting Policies" for additional information on the adoption of ASU 2016-02, *Leases*.

Amortization expense for intangible assets totaled $2.4 billion, $1.0 billion and $817 million for the years ended December 31, 2019, 2018 and 2017, respectively. The projected annual amortization expense for the Company's intangible assets for the next five years is as follows:

In millions	
2020	$ 2,283
2021	2,186
2022	1,816
2023	1,786
2024	1,743

6. Leases

The Company adopted ASU 2016-02, *Leases* (Topic 842) ("ASC 842") on January 1, 2019 on a modified retrospective basis. As a result, the Company's lease disclosures as of and for the year ended December 31, 2019 are reported under ASC 842. Comparative financial information for prior periods has not been restated and continues to be reported under ASC 840, the lease accounting standard in effect for those periods.

Disclosure Subsequent to the Adoption of the New Lease Accounting Standard (ASU 2016-02)

The Company leases most of its retail stores and mail order facilities and certain distribution centers and corporate offices under operating or finance leases, typically with initial terms of 15 to 25 years. The Company also leases certain equipment and other assets under operating or finance leases, typically with initial terms of 3 to 10 years**.**

In addition, the Company leases pharmacy space at the stores of another retail chain for which the noncancelable contractual term of the pharmacy lease arrangement exceeds the remaining estimated economic life of the buildings. For these pharmacy

lease arrangements, the Company concluded that for accounting purposes the lease term was the remaining estimated economic life of the buildings. Consequently, most of these individual pharmacy leases are finance leases.

The following table is a summary of the components of net lease cost for the year ended December 31, 2019:

In millions	**2019**
Operating lease cost	$ 2,720
Finance lease cost:	
Amortization of right-of-use assets	38
Interest on lease liabilities	44
Total finance lease costs	82
Short-term lease costs	24
Variable lease costs	581
Less: sublease income	50
Net lease cost	$ 3,357

Supplemental cash flow information related to leases for the year ended December 31, 2019 is as follows:

In millions	**2019**
Cash paid for amounts included in the measurement of lease liabilities:	
Operating cash flows paid for operating leases	$ 2,701
Operating cash flows paid for interest portion of finance leases	44
Financing cash flows paid for principal portion of finance leases	26
Right-of-use assets obtained in exchange for lease obligations:	
Operating leases	1,824
Finance leases	283

Supplemental balance sheet information related to leases as of December 31, 2019 is as follows:

In millions, except remaining lease term and discount rate		
Operating leases:		
Operating lease right-of-use assets	$	20,860
Current portion of operating lease liabilities	$	1,596
Long-term operating lease liabilities		18,926
Total operating lease liabilities	$	20,522
Finance leases: [1]		
Property and equipment, gross	$	790
Accumulated depreciation [2]		(38)
Property and equipment, net	$	752
Current portion of long-term debt	$	27
Long-term debt		781
Total finance lease liabilities	$	808
Weighted average remaining lease term ***(in years)***		
Operating leases		13.8
Finance leases		20.5
Weighted average discount rate		
Operating leases		4.6%
Finance leases		6.7%

(1) Finance lease right-of-use assets are included within property and equipment, net and the respective finance lease liabilities are included in current portion of long-term debt and long-term debt on the consolidated balance sheets.

(2) In accordance with ASC 842, upon adoption the net carrying value of the prior capital leases became the initial basis of the Company's finance leases. As a result, upon adoption there was no accumulated amortization associated with such finance leases.

The following table summarizes the maturity of lease liabilities under finance and operating leases as of December 31, 2019:

In millions	**Finance Leases**	**Operating Leases [1]**	**Total**
2020	$ 84	$ 2,699	$ 2,783
2021	82	2,598	2,680
2022	79	2,444	2,523
2023	77	2,335	2,412
2024	76	2,103	2,179
Thereafter	1,056	15,654	16,710
Total lease payments [2]	1,454	27,833	29,287
Less: imputed interest	(646)	(7,311)	(7,957)
Total lease liabilities	$ 808	$ 20,522	$ 21,330

(1) Future operating lease payments have not been reduced by minimum sublease rentals of $315 million due in the future under noncancelable subleases.

(2)

The Company leases pharmacy and clinic space from Target Corporation. Amounts related to such finance and operating leases are reflected above. Pharmacy lease amounts due in excess of the remaining estimated economic life of the buildings of approximately $2.2 billion are not reflected in this table since the estimated economic life of the buildings is shorter than the contractual term of the pharmacy lease arrangement.

Sale-Leaseback Transactions
The Company finances a portion of its store development program through sale-leaseback transactions. The properties are generally sold at net book value, which generally approximates fair value, and the resulting leases generally qualify and are accounted for as operating leases. The operating leases that resulted from these transactions are included in the tables above. The Company does not have any retained or contingent interests in the stores and does not provide any guarantees, other than a guarantee of lease payments, in connection with the sale-leaseback transactions. Proceeds from sale-leaseback transactions totaled $5 million in 2019.

Store Rationalization Charges
During the first quarter of 2019, the Company performed a review of its retail stores and determined it would close 46 underperforming retail pharmacy stores during the second quarter of 2019. As a result, management determined that there were indicators of impairment with respect to the impacted stores, including the associated operating lease right-of-use assets. Accordingly, an interim long-lived asset impairment test was performed. The results of the impairment test indicated that the fair value of each store asset group was lower than the carrying value. The fair value was determined using a discounted cash flow method based on estimated sublease income. In the three months ended March 31, 2019, the Company recorded a store rationalization charge of $135 million, primarily related to these operating lease right-of-use asset impairment charges, which was recorded within operating expenses in the Retail/LTC segment.

During the third quarter of 2019, in connection with its annual budgeting process, the Company performed an updated review of its retail stores and determined it would close an additional 22 underperforming retail pharmacy stores during the first quarter of 2020. As a result, management determined that there were indicators of impairment with respect to the impacted stores, including the associated operating lease right-of-use assets. Accordingly, an interim long-lived asset impairment test was performed. The results of the impairment test indicated that the fair value of each store asset group was lower than the carrying value. The fair value was determined using a discounted cash flow method based on estimated sublease income. In the three months ended September 30, 2019, the Company recorded a store rationalization charge of $96 million, primarily related to these operating lease right-of-use asset impairment charges, which was recorded within operating expenses in the Retail/LTC segment.

Comparative Disclosure Prior to the Adoption of the New Lease Accounting Standard (ASU 2016-02)

The following table is a summary of the Company's net rental expense for operating leases for the years ended December 31, 2018 and 2017:

In millions	**2018**	**2017**
Minimum rentals	$ 2,528	$ 2,455
Contingent rentals	28	29
Rental expense	2,556	2,484
Less: sublease income	(21)	(24)
Total rental expense, net	$ 2,535	$ 2,460

The amount of property and equipment under capital leases at December 31, 2018 was as follows:

In millions	**2018**
Property and equipment under capital leases	$ 582
Accumulated amortization of property and equipment under capital leases	(163)
Property and equipment under capital leases, net	$ 419

Sale-Leaseback Transactions
The Company finances a portion of its store development program through sale-leaseback transactions. The properties are generally sold at net book value, which generally approximates fair value, and the resulting leases generally qualify and are accounted for as operating leases. The Company does not have any retained or contingent interests in the stores and does not provide any guarantees, other than a guarantee of lease payments, in connection with the sale-leaseback transactions. There were no sale-leaseback transactions in 2018. Proceeds from sale-leaseback transactions totaled $265 million in 2017.

Store Rationalization Charges
Prior to the adoption of ASC 842, when the Company closed a facility, the present value of estimated unrecoverable costs, including the remaining lease obligation less estimated sublease income and the book value of abandoned property and equipment, were charged to expense. During the year ended December 31, 2018, the Company did not recognize any significant charges related to facility closing costs.

In December 2016, the Company announced an enterprise streamlining initiative designed to reduce costs and enhance operating efficiencies to allow the Company to be more competitive in the current health care environment. During the year ended December 31, 2017, in connection with that enterprise streamlining initiative, the Company closed 71 retail stores and recorded charges of $215 million within operating expenses in the Retail/LTC segment. The charges primarily consist of provisions for the present value of noncancelable lease obligations. The noncancelable lease obligations associated with stores closed during the year ended December 31, 2017 extend through the year 2039.

The long-term portion of the lease obligations associated with all outstanding facility closings was $269 million as of December 31, 2018 and was recorded in other long-term liabilities on the consolidated balance sheets. Upon adoption of ASC 842, the closed store lease obligation was reclassified from a liability to a reduction of the right-of-use asset. Refer to Note 1 "Significant Accounting Policies" for additional discussion regarding the adoption of ASC 842.

7. Health Care Costs Payable

The following is information about incurred and cumulative paid health care claims development as of December 31, 2019, net of reinsurance, and the total IBNR liabilities plus expected development on reported claims included within the net incurred claims amounts. See Note 1 "Significant Accounting Policies" for information on how the Company estimates IBNR reserves and health care costs payable as well as changes to those methodologies, if any. The Company's estimate of IBNR liabilities is primarily based on trend and completion factors. Claim frequency is not used in the calculation of the Company's liability. In addition, it is impracticable to disclose claim frequency information for health care claims due to the Company's inability to gather consistent claim frequency information across its multiple claims processing systems. Any claim frequency count disclosure would not be comparable across the Company's different claim processing systems and would not be consistent from period to period based on the volume of claims processed through each system. As a result, health care claim count frequency is not included in the disclosures below.

The Company acquired Aetna on November 28, 2018. The information about incurred and cumulative paid health care claims development in the table below is presented on a retrospective basis, under which the Company included Aetna's historical development of health care claims for all years presented in the table. The information about incurred and paid health care claims development for the year ended December 31, 2018 is presented as required unaudited supplemental information.

In millions	**Incurred Health Care Claims, Net of Reinsurance For the Years Ended December 31,**	
Date of Service	**2018**	**2019**
	(Unaudited)	
2018	$ 44,962	$ 44,621
2019		51,426
	Total	$ 96,047

In millions	**Cumulative Paid Health Care Claims, Net of Reinsurance For the Years Ended December 31,**	
Date of Service	**2018**	**2019**
	(Unaudited)	
2018	$ 39,440	$ 44,373
2019		44,987
	Total	$ 89,360

All outstanding liabilities for health care costs payable prior to 2018, net of reinsurance		56
Total outstanding liabilities for health care costs payable, net of reinsurance	$	6,743

At December 31, 2019, the Company's liabilities for IBNR plus expected development on reported claims totaled approximately $5.0 billion. Substantially all of the Company's liabilities for IBNR plus expected development on reported claims at December 31, 2019 related to the current calendar year.

The reconciliation of the December 31, 2019 health care net incurred and paid claims development tables to the health care costs payable liability on the consolidated balance sheet is as follows:

In millions	**December 31, 2019**
Short-duration health care costs payable, net of reinsurance	$ 6,743
Reinsurance recoverables	5
Premium deficiency reserve	4
Insurance lines other than short duration	127
Total health care costs payable	$ 6,879

Prior to the Aetna Acquisition on November 28, 2018, the Company's health care costs payable balance was immaterial and related to unpaid pharmacy claims for its SilverScript PDP. Accordingly, the Company has not provided disclosures for health care costs payable for periods prior to 2018. The following table shows the components of the change in health care costs payable during 2019 and 2018:

In millions	**2019**	**2018**
Health care costs payable, beginning of the period	$ 6,147	$ 5
Less: Reinsurance recoverables	4	—
Health care costs payable, beginning of the period, net	6,143	5
Acquisitions, net	—	5,357
Reclassification from pharmacy claims and discounts payable (1)	—	776
Add: Components of incurred health care costs		
Current year	52,723	6,594
Prior years	(524)	(42)
Total incurred health care costs (2)	52,199	6,552
Less: Claims paid		
Current year	46,158	6,303
Prior years	5,314	260
Total claims paid	51,472	6,563
Add: Premium deficiency reserve	4	16
Health care costs payable, end of period, net	6,874	6,143
Add: Reinsurance recoverables	5	4
Health care costs payable, end of period	$ 6,879	$ 6,147

(1) As of the Aetna Acquisition Date, the Company reclassified $776 million of the Pharmacy Services segment's unpaid retail pharmacy claims to third parties from pharmacy claims and discounts payable to health care costs payable as the third party liability was incurred to support the Health Care Benefits segment's insured members.

(2) Total incurred health care costs for the year ended December 31, 2019 and 2018 in the table above exclude (i) $4 million and $16 million, respectively, related to a premium deficiency reserve related to the Company's Medicaid products, (ii) $41 million and $4 million, respectively, of benefit costs recorded in the Health Care Benefits segment that are included in other insurance liabilities on the consolidated balance sheets and (iii) $285 million and $22 million, respectively, of benefit costs recorded in the Corporate/Other segment that are included in other insurance liabilities on the consolidated balance sheets.

The Company's estimates of prior years' health care costs payable decreased by $524 million in 2019 because claims were settled for amounts less than originally estimated (i.e., the amount of claims incurred was lower than originally estimated), primarily due to lower health care cost trends as well as the actual claim submission time being faster than originally assumed (i.e., the Company's completion factors were higher than originally assumed) in estimating health care costs payable at the end of the prior year. This development does not directly correspond to an increase in

the Company's operating results as these reductions were offset by estimated current period health care costs when the Company established the estimate of the current year health care costs payable.

8. Borrowings and Credit Agreements

The following table is a summary of the Company's borrowings as of December 31, 2019 and 2018:

In millions	**2019**	**2018**
Short-term debt		
Commercial paper	$ —	$ 720
Long-term debt		
2.2% senior notes due March 2019	—	375
2.25% senior notes due August 2019	—	850
3.125% senior notes due March 2020	723	2,000
Floating rate notes due March 2020 (2.515% and 3.397% at December 31, 2019 and 2018)	277	1,000
2.8% senior notes due July 2020	2,750	2,750
3.35% senior notes due March 2021	2,038	3,000
Floating rate notes due March 2021 (2.605% and 3.487% at December 31, 2019 and 2018)	1,000	1,000
4.125% senior notes due May 2021	222	550
2.125% senior notes due June 2021	1,750	1,750
4.125% senior notes due June 2021	203	500
5.45% senior notes due June 2021	187	600
3-year tranche term loan due November 2021	—	3,000
3.5% senior notes due July 2022	1,500	1,500
2.75% senior notes due November 2022	1,000	1,000
2.75% senior notes due December 2022	1,250	1,250
4.75% senior notes due December 2022	399	399
3.7% senior notes due March 2023	6,000	6,000
2.8% senior notes due June 2023	1,300	1,300
4% senior notes due December 2023	1,250	1,250
2.625% senior notes due August 2024	1,000	—
3.375% senior notes due August 2024	650	650
3.5% senior notes due November 2024	750	750
5% senior notes due December 2024	299	299
4.1% senior notes due March 2025	5,000	5,000
3.875% senior notes due July 2025	2,828	2,828
2.875% senior notes due June 2026	1,750	1,750
3% senior notes due August 2026	750	—
6.25% senior notes due June 2027	372	372
4.3% senior notes due March 2028	9,000	9,000
3.25% senior notes due August 2029	1,750	—
4.875% senior notes due July 2035	652	652
6.625% senior notes due June 2036	771	771
6.75% senior notes due December 2037	533	533
4.78% senior notes due March 2038	5,000	5,000
6.125% senior notes due September 2039	447	447
5.75% senior notes due May 2041	133	133
4.5% senior notes due May 2042	500	500
4.125% senior notes due November 2042	500	500
5.3% senior notes due December 2043	750	750
4.75% senior notes due March 2044	375	375
5.125% senior notes due July 2045	3,500	3,500
3.875% senior notes due August 2047	1,000	1,000

5.05% senior notes due March 2048	8,000	8,000
Finance lease liabilities	808	642
Other	279	19
Total debt principal	69,246	74,265
Debt premiums	262	302
Debt discounts and deferred financing costs	(1,028)	(1,138)
	68,480	73,429
Less:		
Short-term debt (commercial paper)	—	(720)
Current portion of long-term debt	(3,781)	(1,265)
Long-term debt	$ 64,699	$ 71,444

The following is a summary of the Company's required repayments of debt principal due during each of the next five years and thereafter, as of December 31, 2019:

In millions	
2020	$ 3,754
2021	5,404
2022	4,153
2023	8,554
2024	2,704
Thereafter	43,869
Total	68,438
Finance lease liabilities (1)	808
Total debt principal	$ 69,246

(1) See Note 6 "Leases" for a summary of maturities of the Company's finance lease liabilities.

Short-term Borrowings

Commercial Paper and Back-up Credit Facilities
The Company did not have any commercial paper outstanding as of December 31, 2019. The Company had $720 million of commercial paper outstanding at a weighted average interest rate of 2.8% as of December 31, 2018. In connection with its commercial paper program, the Company maintains a $1.0 billion 364-day unsecured back-up revolving credit facility, which expires on May 14, 2020, a $1.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 18, 2022, a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 17, 2023 and a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 16, 2024. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately .03%, regardless of usage. As of December 31, 2019 and 2018, there were no borrowings outstanding under any of the Company's back-up credit facilities.

Bridge Loan Facility
On December 3, 2017, in connection with the Aetna Acquisition, the Company entered into a $49.0 billion unsecured bridge loan facility commitment. The Company paid $221 million in fees upon entering into the agreement. The fees were capitalized in other current assets and were amortized as interest expense over the period the bridge loan facility commitment was outstanding. The bridge loan facility commitment was reduced to $44.0 billion on December 15, 2017 upon the Company entering into a $5.0 billion term loan agreement. The Company recorded $56 million of amortization of the bridge loan facility fees during the year ended December 31, 2017, which was recorded in interest expense in the consolidated statement of operations.

On March 9, 2018, the Company issued an aggregate of $40.0 billion principal amount of unsecured floating rate notes and unsecured fixed rate senior notes, collectively the "2018 Notes." At that time, the bridge loan facility commitment was reduced to $4.0 billion, and the Company paid $8 million in fees to retain the bridge loan facility commitment through the Aetna Acquisition Date. Those fees were capitalized in other current assets and were amortized as interest expense over the period the bridge loan facility commitment was outstanding. The Company recorded $173 million of amortization of the bridge loan facility commitment fees during the year ended December 31, 2018, which was recorded in interest expense in the consolidated statement of operations. On October 26, 2018, the Company entered into a $4.0 billion unsecured 364-day bridge term loan agreement to formalize the bridge loan facility discussed above. On November 28, 2018, in connection with the Aetna Acquisition, the $4.0 billion unsecured 364-day bridge term loan agreement terminated.

Federal Home Loan Bank of Boston
Since the Aetna Acquisition Date, a subsidiary of the Company is a member of the FHLBB. As a member, the subsidiary has the ability to obtain cash advances, subject to certain minimum collateral requirements. The maximum borrowing capacity available from the FHLBB as of December 31, 2019 was approximately $850 million. At both December 31, 2019 and 2018, there were no outstanding advances from the FHLBB.

Long-term Borrowings

2019 Notes
On August 15, 2019, the Company issued $1.0 billion aggregate principal amount of 2.625% unsecured senior notes due August 15, 2024, $750 million aggregate principal amount of 3% unsecured senior notes due August 15, 2026 and $1.75 billion aggregate principal amount of 3.25% unsecured senior notes due August 15, 2029 (collectively, the "2019 Notes") for total proceeds of approximately $3.5 billion, net of discounts and underwriting fees. The net proceeds of the 2019 Notes were used to repay certain of the Company's outstanding debt.

Beginning in July 2019, the Company entered into several interest rate swap and treasury lock transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of the 2019 Notes. In connection with the issuance of the 2019 Notes, the Company terminated all outstanding cash flow hedges. The Company paid a net amount of $25 million to the hedge counterparties upon termination, which was recorded as a loss, net of tax, of $18 million in accumulated other comprehensive income and will be reclassified as interest expense over the life of the 2019 Notes. See Note 13 "Other Comprehensive Income" for additional information.

Early Extinguishment of Debt
In August 2019, the Company purchased $4.0 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $1.3 billion of its 3.125% senior notes due 2020, $723 million of its floating rate notes due 2020, $328 million of its 4.125% senior notes due 2021, $297 million of 4.125% senior notes due 2021 issued by Aetna, $413 million of 5.45% senior notes due 2021 issued by Coventry Health Care, Inc., a wholly-owned subsidiary of Aetna, and $962 million of its 3.35% senior notes due 2021. In connection with the purchase of such senior notes, the Company paid a premium of $76 million in excess of the aggregate principal amount of the senior notes that were purchased, incurred $8 million in fees and recognized a net gain of $5 million on the write-off of net unamortized deferred financing premiums, for a net loss on early extinguishment of debt of $79 million.

2018 Notes
On March 9, 2018, the Company issued an aggregate of $40.0 billion in principal amount of the 2018 Notes for total proceeds of approximately $39.4 billion, net of discounts and underwriting fees. The net proceeds of the 2018 Notes were used to fund a portion of the Aetna Acquisition. The 2018 Notes consisted of the following at the time of issuance:

In millions	
3.125% senior notes due March 2020	$ 2,000
Floating rate notes due March 2020	1,000
3.35% senior notes due March 2021	3,000
Floating rate notes due March 2021	1,000
3.7% senior notes due March 2023	6,000
4.1% senior notes due March 2025	5,000
4.3% senior notes due March 2028	9,000
4.78% senior notes due March 2038	5,000
5.05% senior notes due March 2048	8,000
Total debt principal	$ 40,000

From December 2017 through March 2018, the Company entered into several interest rate swap and treasury lock transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of long-term debt to fund the Aetna Acquisition.

In connection with the issuance of the 2018 Notes, the Company terminated all outstanding cash flow hedges. In connection with the hedge transactions, the Company received a net amount of $446 million from the hedge counterparties upon termination, which was recorded as a gain, net of tax, of $331 million in accumulated other

comprehensive income and will be reclassified as a reduction of interest expense over the life of the 2018 Notes. See Note 13 ‘‘Other Comprehensive Income’’ for additional information.

Term Loan Agreement
On December 15, 2017, in connection with the Aetna Acquisition, the Company entered into a $5.0 billion term loan agreement. The term loan agreement allowed for borrowings at various rates that were dependent, in part, on the Company's debt ratings. In connection with the Aetna Acquisition, the Company borrowed $5.0 billion (a $3.0 billion three-year tranche and a $2.0 billion five-year tranche) under the term loan agreement in November 2018. The Company terminated the $2.0 billion five-year tranche in December 2018 with the repayment of the borrowing. The Company made principal payments of $500 million in March 2019, $1.0 billion in May 2019 and $1.5 billion in July 2019 on the three-year tranche, and terminated the three-year tranche and the term loan agreement with the final repayment of the borrowing in July 2019, at which time the Company had repaid all term loans.

Aetna Related Debt
Upon the closing of the Aetna Acquisition, the Company assumed long-term debt with a fair value of $8.1 billion, with stated interest rates ranging from 2.2% to 6.75%. The long-term debt assumed is included in the summary of the Company's borrowings table above.

Debt Covenants

The Company's back-up revolving credit facilities, unsecured senior notes and unsecured floating rate notes contain customary restrictive financial and operating covenants. These covenants do not include an acceleration of the Company's debt maturities in the event of a downgrade in the Company's credit ratings. The Company does not believe the restrictions contained in these covenants materially affect its financial or operating flexibility. As of December 31, 2019, the Company was in compliance with all of its debt covenants.

9. Pension Plans and Other Postretirement Benefits

Defined Contribution Plans

As of December 31, 2019, the Company sponsors several active 401(k) savings plans that cover all employees who meet plan eligibility requirements. The Company makes matching contributions consistent with the provisions of the respective plans.

At the participant's option, account balances, including the Company's matching contribution, can be invested among various investment options under each plan. Two of the defined contribution plans offer the Company's common stock fund as an investment option. The Company also maintains nonqualified, unfunded deferred compensation plans for certain key employees. The plans provide participants the opportunity to defer portions of their eligible compensation and for certain nonqualified plans, participants receive matching contributions equivalent to what they could have received under the CVS Health Future Fund 401(k) Plan or Aetna 401(k) Plan absent certain restrictions and limitations under the Internal Revenue Code. The Company's contributions under the above defined contribution plans were $550 million, $334 million and $314 million in 2019, 2018 and 2017, respectively. The Company's contributions for the years ended December 31, 2019 and 2018 include contributions to the Aetna Inc. 401(k) plan subsequent to the Aetna Acquisition Date.

Defined Benefit Pension Plans

On November 28, 2018, the Company completed the Aetna Acquisition. Aetna sponsors a tax-qualified defined benefit pension plan that was frozen in 2010. Aetna also sponsors a nonqualified supplemental pension plan that was frozen in 2007. Aetna's pension plan benefit obligations and the fair value of plan assets were remeasured as of the Aetna Acquisition Date.

Prior to the Aetna Acquisition, during the year ended December 31, 2017, the Company settled the pension obligations of its two existing tax-qualified defined benefit pension plans by irrevocably transferring pension liabilities to an insurance company through the purchase of group annuity contracts and through lump sum distributions. These purchases, funded with pension plan assets, resulted in pre-tax settlement losses of $187 million in the year ended December 31, 2017, related to the recognition of accumulated deferred actuarial losses. The settlement losses were recorded in other expense in the consolidated statement of operations. The Company also sponsors several other defined benefit pension plans that are unfunded nonqualified supplemental retirement plans.

Pension Benefit Obligation and Plan Assets
The following tables outline the change in pension benefit obligation and plan assets over the specified periods:

In millions	**2019**	**2018**
Change in benefit obligation:		
Benefit obligation, beginning of year	$ 5,841	$ 131
Acquired benefit obligations	—	5,685
Interest cost	225	25
Actuarial loss	530	41
Benefit payments	(357)	(41)
Benefit obligation, end of year	6,239	5,841
Change in plan assets:		
Fair value of plan assets, beginning of year	5,663	—
Fair value of plan assets acquired	—	5,709
Actual return on plan assets	1,064	(17)
Employer contributions	25	12
Benefit payments	(357)	(41)
Fair value of plan assets, end of year	6,395	5,663
Funded status	$ 156	$ (178)

The assets (liabilities) recognized on the consolidated balance sheets at December 31, 2019 and 2018 for the pension plans consisted of the following:

In millions	**2019**	**2018**
Non-current assets reflected in other assets	$ 494	$ 147
Current liabilities reflected in accrued expenses	(25)	(25)
Non-current liabilities reflected in other long-term liabilities	(313)	(300)
Net assets (liabilities)	$ 156	$ (178)

Net Periodic Benefit Cost (Income)
The components of net periodic benefit cost (income) for the years ended December 31, 2019, 2018 and 2017 are shown below:

In millions	**2019**	**2018**	**2017**
Components of net periodic benefit cost (income):			
Interest cost	$ 225	$ 25	$ 20
Expected return on plan assets	(357)	(33)	(20)
Amortization of net actuarial loss	1	2	21
Settlement losses	—	—	187
Net periodic benefit cost (income)	$ (131)	$ (6)	$ 208

Pension Plan Assumptions
The Company uses a series of actuarial assumptions to determine its benefit obligation and net periodic benefit cost (income), including discount rates and expected return on plan assets assumptions, as further detailed below.

Discount Rates - The discount rate is determined using a yield curve as of the annual measurement date. The yield curve consists of a series of individual discount rates, with each discount rate corresponding to a single point in time, based on high-quality bonds. Projected benefit payments are discounted to the measurement date using the corresponding rate from the yield curve that is consistent with the maturity profile of the expected liability cash flows.

Expected Return on Plan Assets - The expected long-term rate of return on plan assets is determined by using the plan's target allocation and return expectations based on many factors including forecasted long-term capital market real returns and the inflationary outlook on a plan by plan basis. See "Pension Plan Assets" below for additional details regarding the pension plan assets as of December 31, 2019 and 2018.

The Company determined its benefit obligation based on the following weighted average assumptions as of December 31, 2019 and 2018:

	2019	2018
Discount rate	3.2%	4.3%

The Company determined its net periodic benefit cost (income) based on the following weighted average assumptions for the years ended December 31, 2019, 2018 and 2017:

	2019	2018	2017
Discount rate	4.0%	4.0%	4.0%
Expected long-term rate of return on plan assets	6.5%	6.6%	5.0%

Pension Plan Assets
As of December 31, 2017, the assets in the Company's tax-qualified defined benefit pension plans had been fully liquidated to settle all plan obligations through the purchase of group annuity contracts and through lump sum distributions. Subsequent to the Aetna Acquisition Date, the Company's pension plan assets primarily include debt and equity securities held in separate accounts, common/collective trusts and real estate investments. The valuation methodologies used to value these debt and equity securities and common/collective trusts are similar to the methodologies described in Note 4 "Fair Value." Pension plan assets also include investments in other assets that are carried at fair value. The following is a description of the valuation methodologies used to value real estate investments and these additional investments, including the general classification pursuant to the fair value hierarchy.

Real Estate - Real estate investments are valued by independent third party appraisers. The appraisals comply with the Uniform Standards of Professional Appraisal Practice, which include, among other things, the income, cost, and sales comparison approaches to estimating property value. Therefore, these investments are classified in Level 3.

Private equity and hedge fund limited partnerships - Private equity and hedge fund limited partnerships are carried at fair value which is estimated using the NAV per unit as reported by the administrator of the underlying investment fund as a practical expedient to fair value. Therefore, these investments have been excluded from the fair value table below.

Pension plan assets with changes in fair value measured on a recurring basis at December 31, 2019 were as follows:

In millions	**Level 1**	**Level 2**	**Level 3**	**Total**
Cash and cash equivalents	$ 92	$ 65	$ —	$ 157
Debt securities:				
U.S. government securities	592	31	—	623
States, municipalities and political subdivisions	—	157	—	157
U.S. corporate securities	—	1,849	1	1,850
Foreign securities	—	178	—	178
Residential mortgage-backed securities	—	385	—	385
Commercial mortgage-backed securities	—	89	—	89
Other asset-backed securities	—	150	—	150
Redeemable preferred securities	—	5	—	5
Total debt securities	592	2,844	1	3,437
Equity securities:				
U.S. domestic	931	1	—	932
International	481	—	—	481
Domestic real estate	25	—	—	25
Total equity securities	1,437	1	—	1,438
Other investments:				
Real estate	—	—	353	353
Common/collective trusts [1]	—	288	—	288
Derivatives	—	(2)	—	(2)
Total other investments	—	286	353	639
Total pension investments [2]	$ 2,121	$ 3,196	$ 354	$ 5,671

(1) The assets in the underlying funds of common/collective trusts consist of $137 million of equity securities and $151 million of debt securities.

(2) Excludes $540 million of private equity limited partnership investments and $184 million of hedge fund limited partnership investments as these amounts are measured at NAV per share or an equivalent and are not subject to leveling within the fair value hierarchy.

Pension plan assets with changes in fair value measured on a recurring basis at December 31, 2018 were as follows:

In millions	**Level 1**	**Level 2**	**Level 3**	**Total**
Cash and cash equivalents	$ 68	$ 30	$ —	$ 98
Debt securities:				
U.S. government securities	511	38	—	549
States, municipalities and political subdivisions	—	147	—	147
U.S. corporate securities	—	1,671	5	1,676
Foreign securities	—	177	—	177
Residential mortgage-backed securities	—	339	—	339
Commercial mortgage-backed securities	—	70	—	70
Other asset-backed securities	—	162	—	162
Redeemable preferred securities	—	6	—	6
Total debt securities	511	2,610	5	3,126
Equity securities:				
U.S. domestic	744	—	—	744
International	356	—	—	356
Domestic real estate	30	—	—	30
Total equity securities	1,130	—	—	1,130
Other investments:				
Real estate	—	—	425	425
Common/collective trusts [1]	—	253	—	253
Derivatives	—	2	—	2
Total other investments	—	255	425	680
Total pension investments [2]	$ 1,709	$ 2,895	$ 430	$ 5,034

(1) The assets in the underlying funds of common/collective trusts consist of $109 million of equity securities and $144 million of debt securities.

(2) Excludes $465 million of private equity limited partnership investments and $164 million of hedge fund limited partnership investments as these amounts are measured at NAV per share or an equivalent and are not subject to leveling within the fair value hierarchy.

The changes in the balance of Level 3 pension plan assets during 2019 were as follows:

	2019		
In millions	**Real estate**	**U.S. corporate securities**	**Total**
Beginning balance	$ 425	$ 5	$ 430
Actual return on plan assets	5	—	5
Purchases, sales and settlements	(77)	(5)	(82)
Transfers into (out of) Level 3	—	1	1
Ending balance	$ 353	$ 1	$ 354

The increase in the balance of Level 3 pension plan assets during 2018 relates to investments acquired in the Aetna Acquisition. There was an immaterial amount of transfers into or out of Level 3 from the Aetna Acquisition Date to December 31, 2018.

The Company's pension plan invests in a diversified mix of assets intended to maximize long-term returns while recognizing the need for adequate liquidity to meet ongoing benefit and administrative obligations. The risk of unexpected investment and actuarial outcomes is regularly evaluated. This evaluation is performed through forecasting and assessing ranges of investment outcomes over short- and long-term horizons and by assessing the pension plan's liability characteristics. Complementary investment styles and strategies are utilized by multiple

investment management firms to further improve portfolio and operational risk characteristics. Public and private equity investments are used primarily to increase overall plan returns. Real estate investments are viewed favorably for their diversification benefits and above-average dividend generation. Fixed income

investments provide diversification benefits and liability hedging attributes that are desirable, especially in falling interest rate environments.

At December 31, 2019, target investment allocations for the Company's pension plan were: 33% in equity securities, 54% in debt securities, 6% in real estate, 4% in private equity limited partnerships and 3% in hedge funds. Actual asset allocations may differ from target allocations due to tactical decisions to overweight or underweight certain assets or as a result of normal fluctuations in asset values. Asset allocations are consistent with stated investment policies and, as a general rule, periodically rebalanced back to target asset allocations. Asset allocations and investment performance are formally reviewed periodically throughout the year by the pension plan's Benefit Finance Committee. Forecasting of asset and liability growth is performed at least annually.

Cash Flows
The Company generally contributes to its tax-qualified pension plan based on minimum funding requirements determined under applicable federal laws and regulations. Employer contributions related to the nonqualified supplemental pension plans generally represent payments to retirees for current benefits. The Company contributed $25 million, $12 million and $46 million to its pension plans during 2019, 2018 and 2017, respectively. No contributions are required for the tax-qualified pension plan in 2020. The Company expects to make an immaterial amount of contributions for all other pension plans in 2020. The Company estimates the following future benefit payments, which are calculated using the same actuarial assumptions used to measure the pension benefit obligation as of December 31, 2019:

In millions	
2020	$ 373
2021	415
2022	379
2023	384
2024	380
2025-2029	1,851

Multiemployer Pension Plans
The Company also contributes to a number of multiemployer pension plans under the terms of collective-bargaining agreements that cover its union-represented employees. The risks of participating in these multiemployer plans are different from single-employer pension plans in the following respects: (i) assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers, (ii) if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers, and (iii) if the Company chooses to stop participating in some of its multiemployer plans, the Company may be required to pay those plans an amount based on the underfunded status of the applicable plan, which is referred to as a withdrawal liability.

None of the multiemployer pension plans in which the Company participates are individually significant to the Company. The Company's contributions to multiemployer pension plans were $18 million, $18 million and $17 million in 2019, 2018 and 2017, respectively.

Other Postretirement Benefits

The Company provides postretirement health care and life insurance benefits to certain retirees who meet eligibility requirements. During 2018, the Company acquired additional OPEB plans in connection with the Aetna Acquisition. The Company's funding policy is generally to pay covered expenses as they are incurred. For retiree medical plan accounting, the Company reviews external data and its own historical trends for health care costs to determine the health care cost trend rates. As of December 31, 2019 and 2018, the Company's other postretirement benefits had an accumulated postretirement benefit obligation of $246 million and $228 million, respectively. Net periodic benefit costs related to these other postretirement benefits were $7 million, $2 million and $1 million in 2019, 2018 and 2017, respectively.

The Company estimates the following future benefit payments, which are calculated using the same actuarial assumptions used to measure the accumulated other postretirement benefit obligation as of December 31, 2019:

In millions	
2020	$ 15
2021	15
2022	15
2023	15
2024	15
2025-2029	72

Pursuant to various collective bargaining agreements, the Company also contributes to multiemployer health and welfare plans that cover certain union-represented employees. The plans provide postretirement health care and life insurance benefits to certain employees who meet eligibility requirements. The Company's contributions to multiemployer health and welfare plans totaled $57 million, $58 million and $58 million in 2019, 2018 and 2017, respectively.

10. Income Taxes

The income tax provision (benefit) for continuing operations consisted of the following for the years ended December 31, 2019, 2018 and 2017:

In millions	**2019**	**2018**	**2017**
Current:			
Federal	$ 2,450	$ 1,480	$ 2,594
State	565	499	464
	3,015	1,979	3,058
Deferred:			
Federal	(535)	22	(1,435)
State	(114)	1	14
	(649)	23	(1,421)
Total	$ 2,366	$ 2,002	$ 1,637

The TCJA was enacted on December 22, 2017. Among numerous changes to existing tax laws, the TCJA permanently reduced the federal corporate income tax rate from 35% to 21% effective on January 1, 2018. The effects of changes in tax rates on deferred tax balances are required to be taken into consideration in the period in which the changes are enacted, regardless of when they are effective. As a result of the reduction of the corporate income tax rate under the TCJA, the Company estimated the revaluation of its net deferred tax liabilities and recorded a provisional income tax benefit of approximately $1.5 billion for year ended December 31, 2017. In 2018, the Company completed its process of determining the TCJA's final impact and recorded an additional income tax benefit of $100 million.

The following table is a reconciliation of the statutory income tax rate to the Company's effective income tax rate for continuing operations for the years ended December 31, 2019, 2018 and 2017:

	2019	**2018**	**2017**
Statutory income tax rate	21.0%	21.0 %	35.0 %
State income taxes, net of federal tax benefit	4.0	27.7	4.1
Effect of the Tax Cuts and Jobs Act	—	(7.1)	(18.3)
Health insurer fee	—	2.2	—
Goodwill impairments	—	89.5	0.8
Sale of subsidiary	—	5.0	—

Other	1.3	4.1	(1.8)
Effective income tax rate	26.3%	142.4 %	19.8 %

The following table is a summary of the components of the Company's deferred income tax assets and liabilities as of December 31, 2019 and 2018:

In millions	**2019**	**2018**
Deferred income tax assets:		
Lease and rents	$ 267	$ 277
Inventory	23	28
Employee benefits	191	243
Bad debts and other allowances	294	243
Retirement benefits	47	130
Net operating loss and capital loss carryforwards	480	529
Deferred income	36	104
Insurance reserves	430	467
Investments	—	11
Other	451	242
Valuation allowance	(374)	(520)
Total deferred income tax assets	1,845	1,754
Deferred income tax liabilities:		
Investments	(289)	—
Depreciation and amortization	(8,850)	(9,431)
Total deferred income tax liabilities	(9,139)	(9,431)
Net deferred income tax liabilities	$ (7,294)	$ (7,677)

As of December 31, 2019, the Company has net operating and capital loss carryovers of $480 million, which expire between 2021 and 2038. The Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax planning strategies and the Company's recent operating results. The Company established a valuation allowance of $374 million because it does not consider it more likely than not that these deferred tax assets will be recovered.

A reconciliation of the beginning and ending amount of unrecognized tax benefits as of December 31, 2019, 2018 and 2017 is as follows:

In millions	**2019**	**2018**	**2017**
Beginning balance	$ 661	$ 344	$ 307
Additions based on tax positions related to the current year	4	1	62
Additions based on tax positions related to prior years	115	324	32
Reductions for tax positions of prior years	(111)	(5)	(28)
Expiration of statutes of limitation	(7)	(2)	(10)
Settlements	(7)	(1)	(19)
Ending balance	$ 655	$ 661	$ 344

The increase in the balance of unrecognized tax benefits in 2018 compared to 2017 was mainly due to the Aetna Acquisition.

The Company and most of its subsidiaries are subject to U.S. federal income tax as well as income tax of numerous state and local jurisdictions. The Company is a participant in the Compliance Assurance Process, which is a program made available by the U.S. Internal Revenue Service ("IRS") to certain qualifying large taxpayers, under which participants work collaboratively with the IRS to identify and resolve potential tax issues through open, cooperative and transparent interaction prior to the annual filing of their federal income tax returns. The IRS has completed its examinations of the Company's consolidated U.S. federal income tax returns through tax year 2013. The IRS has substantially completed its examinations of the Company's consolidated U.S. federal income tax returns for tax years

2014 through 2018. The IRS is currently examining the Company's 2019 consolidated U.S. federal income tax return.

The Company and its subsidiaries are also currently under income tax examinations by a number of state and local tax authorities. As of December 31, 2019, no examination has resulted in any proposed adjustments that would result in a material change to the Company's operating results, financial condition or liquidity.

Substantially all material state and local income tax matters have been concluded for fiscal years through 2014. Certain state exams are likely to be concluded and certain state statutes of limitations will lapse in 2020, but the change in the balance of the Company's uncertain tax positions is projected to be immaterial. In addition, it is reasonably possible that the Company's unrecognized tax benefits could change within the next twelve months due to the anticipated conclusion of various examinations with the IRS for various years. An estimate of the range of the possible change cannot be made at this time.

The Company records interest expense related to unrecognized tax benefits and penalties in the income tax provision. The Company accrued interest expense of approximately $49 million, $19 million and $11 million in 2019, 2018 and 2017, respectively. The Company had approximately $173 million and $80 million accrued for interest and penalties as of December 31, 2019 and 2018, respectively.

As of December 31, 2019, the total amount of unrecognized tax benefits that, if recognized, would affect the Company's effective income tax rate is approximately $532 million, after considering the federal benefit of state income taxes.

11. Stock Incentive Plans

The terms of the CVS Health 2017 Incentive Compensation Plan ("ICP") provide for grants of annual incentive and long-term performance awards to executive officers and other officers and employees of the Company or any subsidiary of the Company, as well as equity compensation to outside directors of CVS Health. Payment of such annual incentive and long-term performance awards will be in cash, stock, other awards or other property, at the discretion of the Management Planning and Development Committee (the "MP&D Committee") of CVS Health's Board of Directors (the "Board"). The ICP allows for a maximum of 32 million shares of CVS Health common stock to be reserved and available for grants. Prior to the acquisition of Aetna in 2018, the ICP was the only compensation plan under which the Company granted stock options, restricted stock and other stock-based awards to its employees, with the exception of the Company's Employee Stock Purchase Plan ("ESPP"). As of December 31, 2019, there were approximately 17 million shares of CVS Health common stock available for future grants under the ICP.

As of the Aetna Acquisition Date, approximately 22 million shares of Aetna common stock subject to awards outstanding under the Amended Aetna Inc. 2010 Stock Incentive Plan ("SIP") were assumed by CVS Health. In addition, in accordance with the merger agreement, shares which were available for future issuance under the SIP were converted into approximately 32 million shares of CVS Health common stock reserved and available for issuance pursuant to future awards. As of December 31, 2019, there were approximately 27 million shares of CVS Health common stock available for future grants under the SIP.

Stock-Based Compensation Expense

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as expense over the requisite service period of the stock award (generally three to five years) using the straight-line method. The following table is a summary of stock-based compensation for the years ended December 31, 2019, 2018 and 2017:

In millions	**2019**	**2018**	**2017**
Stock options and stock appreciation rights ("SARs") (1) (2)	$ 76	$ 70	$ 65
Restricted stock units and performance stock units (2)	377	210	169
Total stock-based compensation	$ 453	$ 280	$ 234

(1) Includes the ESPP.

(2) Stock-based compensation for the year ended December 31, 2018 includes $14 million and $27 million associated with accelerated vesting of SARs and restricted stock replacement awards, respectively, issued to Aetna employees who were terminated subsequent to the Aetna Acquisition.

ESPP

The ESPP provides for the purchase of up to 30 million shares of CVS Health common stock. Under the ESPP, eligible employees may purchase common stock at the end of each six month offering period at a purchase price equal to 90% of the lower of the fair market value on the first day or the last day of the offering period. During 2019, approximately two million

shares of common stock were purchased under the provisions of the ESPP at an average price of $53.29 per share. As of December 31, 2019, approximately seven million shares of common stock were available for issuance under the ESPP.

The fair value of stock-based compensation associated with the ESPP is estimated on the date of grant (the first day of the six month offering period) using the Black-Scholes option pricing model.

The following table is a summary of the assumptions used to value the ESPP awards for the years ended December 31, 2019, 2018 and 2017:

	2019	2018	2017
Dividend yield [1]	1.70%	1.45%	1.24%
Expected volatility [2]	27.96%	28.02%	22.70%
Risk-free interest rate [3]	2.27%	1.87%	0.86%
Expected life (in years) [4]	0.5	0.5	0.5
Weighted-average grant date fair value	$ 10.51	$ 12.26	$ 13.01

(1) The dividend yield is calculated based on semi-annual dividends paid and the fair market value of CVS Health stock at the grant date.

(2) The expected volatility is estimated based on the historical volatility of CVS Health's daily stock price over the previous six month period.

(3) The risk-free interest rate is selected based on the Treasury constant maturity interest rate whose term is consistent with the expected term of ESPP purchases (i.e., six months).

(4) The expected life is based on the semi-annual purchase period.

Restricted Stock Units and Performance Stock Units

The Company's restricted stock units and performance stock units are considered nonvested share awards and require no payment from the employee. The fair value of the restricted stock units is based on the market price of CVS Health common stock on the grant date and is recognized on a straight-line basis over the vesting period. For each restricted stock unit granted, employees receive one share of common stock, net of taxes, at the end of the vesting period.

The Company's performance stock units contain performance vesting conditions in addition to a service vesting condition. Vesting of the Company's performance stock units is dependent upon the degree to which the Company achieves its performance goals, which are generally set for a three-year performance period and are approved at the time of grant by the MP&D Committee.

The fair value of performance stock units granted with service and performance vesting conditions is based on the market price of CVS Health common stock on the grant date and is recognized over the vesting period. Certain of the performance stock units also contain a market vesting condition based on the performance of CVS Health common stock relative to a comparator group. The fair value of these performance stock units is determined using a Monte Carlo simulation as of the grant date and is recognized over the vesting period.

On November 28, 2018, the Company completed the Aetna Acquisition. All unvested Aetna performance stock unit and restricted stock unit awards as of the Aetna Acquisition Date were converted into replacement CVS Health restricted stock awards.

As of December 31, 2019, there was $524 million of total unrecognized compensation cost related to the Company's restricted stock units and performance stock units that are expected to vest. These costs are expected to be recognized over a weighted-average period of 2.2 years. The total fair value of restricted stock units vested during 2019, 2018 and 2017 was $265 million, $262 million and $175 million, respectively.

The following table is a summary of the restricted stock unit and performance stock unit activity for the year ended December 31, 2019:

In thousands, except weighted average grant date fair value	Units	Weighted Average Grant Date Fair Value
Outstanding at beginning of year, nonvested	11,005	$ 76.18
Granted	7,644	$ 54.34
Vested	(4,216)	$ 62.59
Forfeited	(1,308)	$ 58.73
Outstanding at end of year, nonvested	13,125	$ 61.57

Stock Options and SARs

All stock option grants are awarded at fair value on the date of grant. The fair value of stock options is estimated using the Black-Scholes option pricing model, and stock-based compensation is recognized on a straight-line basis over the requisite service period. Stock options granted generally become exercisable over a four-year period from the grant date. Stock options granted prior to 2019 generally expire seven years after the grant date. Stock options granted in 2019 expire ten years after the grant date.

On November 28, 2018, the Company completed the Aetna Acquisition. All unvested Aetna SARs outstanding as of the Aetna Acquisition Date were converted into replacement CVS Health SARs. The replacement SARs granted will be settled in CVS Health common stock, net of taxes, based on the appreciation of the stock price on the exercise date over the market price on the date of grant. The fair value of SARs is estimated using the Black-Scholes option pricing model, and stock-based compensation is recognized on a straight-line basis over the requisite service period. SARs generally become exercisable over a three-year period from the grant date. SARs generally expire ten years after the grant date.

The following table is a summary of stock option and SAR activity that occurred for the years ended December 31, 2019, 2018 and 2017:

In millions	2019	2018	2017
Cash received from stock options exercised (including ESPP)	$ 210	$ 242	$ 329
Payments for taxes for net share settlement of equity awards	112	97	71
Intrinsic value of stock options and SARs exercised	30	79	176
Fair value of stock options and SARs vested	467	324	341

The fair value of each stock option and SAR is estimated using the Black-Scholes option pricing model based on the following assumptions at the time of grant:

	2019	2018	2017
Dividend yield [1]	3.68%	2.76%	2.56%
Expected volatility [2]	21.76%	21.27%	18.39%
Risk-free interest rate [3]	0.56%	2.77%	1.77%
Expected life (in years) [4]	6.3	4.8	4.1
Weighted-average grant date fair value	$ 6.27	$ 24.55	$ 9.43

(1) The dividend yield is based on annual dividends paid and the fair market value of CVS Health stock at the grant date.

(2) The expected volatility is estimated based on the historical volatility of CVS Health's daily stock price over a period equal to the expected life of each option or SAR grant after adjustments for infrequent events such as stock splits.

(3) The risk-free interest rate is selected based on yields from U.S. Treasury zero-coupon issues with a remaining term equal to the expected term of the options or SARs being valued.

(4) The expected life represents the number of years the options or SARs are expected to be outstanding from grant date based on historical option or SAR holder exercise experience.

The increase in the weighted-average grant date fair value in 2018 was due to the issuance of the replacement SARs in connection with the Aetna Acquisition.

As of December 31, 2019, unrecognized compensation expense related to unvested stock options and SARs totaled $41 million, which the Company expects to be recognized over a weighted-average period of 2.1 years. After considering anticipated forfeitures, the Company expects approximately 10 million of the unvested stock options and SARs to vest over the requisite service period.

The following table is a summary of the Company's stock option and SAR activity for the year ended December 31, 2019:

In thousands, except weighted average exercise price and remaining contractual term	**Shares**	**Weighted Average Exercise Price**	**Weighted Average Remaining Contractual Term**	**Aggregate Intrinsic Value**
Outstanding at beginning of year	22,909	$ 71.15		
Granted	6,538	$ 54.40		
Exercised	(3,667)	$ 46.17		
Forfeited	(769)	$ 68.12		
Expired	(1,109)	$ 82.40		
Outstanding at end of year	23,902	$ 69.98	4.76	$ 274,987
Exercisable at end of year	13,267	$ 77.48	2.73	109,765
Vested at end of year and expected to vest in the future	23,328	$ 70.28	4.67	265,128

12. Shareholders' Equity

Share Repurchases

The following share repurchase programs have been authorized by the Board:

In billions **Authorization Date**	**Authorized**	**Remaining as of December 31, 2019**
November 2, 2016 ("2016 Repurchase Program")	$ 15.0	$ 13.9
December 15, 2014 ("2014 Repurchase Program")	10.0	—

Each of the share Repurchase Programs was effective immediately. The 2014 Repurchase Program has been completed. The 2016 Repurchase Program permits the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase ("ASR") transactions, and/or other derivative transactions. The 2016 Repurchase Program can be modified or terminated by the Board at any time.

During the years ended December 31, 2019 and 2018, the Company did not repurchase any shares of common stock pursuant to the 2016 Repurchase Program. During the year ended December 31, 2017, the Company repurchased an aggregate of 55.4 million shares of common stock for approximately $4.4 billion under the 2014 and 2016 Repurchase Programs, a significant portion of which were repurchased through two ASR transactions which are further described below.

Pursuant to the authorization under the 2014 Repurchase Program, in August 2016, the Company entered into two fixed dollar ASRs with Barclays Bank PLC ("Barclays") for a total of $3.6 billion. Upon payment of the $3.6 billion purchase price in January 2017, the Company received a number of shares of CVS Health common stock equal to 80% of the $3.6 billion notional amount of the ASRs or approximately 36.1 million shares, which were placed into treasury stock in January 2017. The ASRs were accounted for as an initial treasury stock transaction for $2.9 billion and a forward contract for $0.7 billion. In April 2017, the Company received an additional 9.9 million shares of CVS Health common stock, representing the remaining 20% of the $3.6 billion notional amount of the ASRs, thereby concluding the ASRs. The additional 9.9 million shares of common stock delivered to the Company by Barclays were placed into treasury stock, and the forward contract was reclassified from capital surplus to treasury stock in April 2017.

Dividends

The quarterly cash dividend declared by the Board was $0.50 per share in 2019 and 2018. CVS Health has paid cash dividends every quarter since becoming a public company. Future dividend payments will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

Regulatory Requirements

On November 28, 2018, the Company completed the Aetna Acquisition. Aetna's insurance business operations are conducted through subsidiaries that principally consist of HMOs and insurance companies. The Company's HMO and insurance subsidiaries report their financial statements in accordance with accounting practices prescribed by state regulatory authorities which may differ from GAAP.

The combined statutory net income of the Company's insurance and HMO subsidiaries for the year ended December 31, 2019 was $2.8 billion and for the year ended December 31, 2018 (which includes Aetna and its subsidiaries from November 28, 2018 to December 31, 2018) was not material. The estimated combined statutory capital and surplus at December 31, 2019 and 2018 of the Company's insurance and HMO subsidiaries was approximately $11.0 billion and $10.1 billion, respectively. The Company's insurance and HMO subsidiaries paid $2.4 billion of gross dividends to the Company for the year ended December 31, 2019.

In addition to general state law restrictions on payments of dividends and other distributions to stockholders applicable to all corporations, HMOs and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity and restrict the amount of dividends and other distributions that may be paid to their equity holders. In addition, in connection with the Aetna Acquisition, the Company made certain undertakings that require prior regulatory approval of dividends by certain of its HMOs and insurance companies. At December 31, 2019, these amounts were as follows:

In millions		
Estimated minimum statutory surplus required by regulators	$	5,841
Investments on deposit with regulatory bodies		672
Estimated maximum dividend distributions permitted in 2020 without prior regulatory approval		366

Noncontrolling Interests

At December 31, 2019 and 2018, noncontrolling interests were $306 million and $318 million, respectively, primarily related to third party interests in the Company's operating entities. The noncontrolling entities' share is included in total shareholders' equity on the consolidated balance sheets.

13. Other Comprehensive Income

Shareholders' equity included the following activity in accumulated other comprehensive income (loss) in 2019, 2018 and 2017:

	At December 31,		
In millions	**2019**	**2018**	**2017**
Net unrealized investment gains:			
Beginning of year balance	$ 97	$ —	$ —
Other comprehensive income before reclassifications *($927, $132 and $0 pretax)*	763	97	—
Amounts reclassified from accumulated other comprehensive income *($(105), $1 and $0 pretax)* (1)	(86)	—	—
Other comprehensive income	677	97	—
End of year balance	774	97	—
Foreign currency translation adjustments:			
Beginning of year balance	(158)	(129)	(127)
Other comprehensive income (loss) before reclassifications	8	(29)	(2)
Amounts reclassified from accumulated other comprehensive loss (2)	154	—	—
Other comprehensive income (loss)	162	(29)	(2)
End of year balance	4	(158)	(129)
Net cash flow hedges:			
Beginning of year balance	312	(15)	(5)
Adoption of new accounting standard (3)	—	(3)	—
Other comprehensive income (loss) before reclassifications *($(25), $465 and $(18) pretax)*	(18)	344	(11)
Amounts reclassified from accumulated other comprehensive income (loss) *($(20), $(19) and $2 pretax)* (4)	(15)	(14)	1
Other comprehensive income (loss)	(33)	330	(10)
End of year balance	279	312	(15)
Pension and other postretirement benefits:			
Beginning of year balance	(149)	(21)	(173)
Adoption of new accounting standard (3)	—	(4)	—
Other comprehensive income (loss) before reclassifications *($162, $(178) and $0 pretax)*	120	(132)	—
Amounts reclassified from accumulated other comprehensive loss *($(12), $11 and $249 pretax)* (5)	(9)	8	152
Other comprehensive income (loss)	111	(124)	152
End of year balance	(38)	(149)	(21)
Total beginning of year accumulated other comprehensive income (loss)	102	(165)	(305)
Adoption of new accounting standard (3)	—	(7)	—
Total other comprehensive income	917	274	140
Total end of year accumulated other comprehensive income (loss)	$ 1,019	$ 102	$ (165)

(1) Amounts reclassified from accumulated other comprehensive income for specifically identified debt securities are included in net investment income in the consolidated statements of operations.

(2)

Amounts reclassified from accumulated other comprehensive loss represent the elimination of the cumulative translation adjustment associated with the sale of Onofre, which was sold on July 1, 2019. The loss on the divestiture of Onofre is reflected in operating expenses in the consolidated statements of operations.

(3) Reflects the adoption of ASU 2018-02, *Income Statement Reporting Comprehensive Income (Topic 220); Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income* during the year ended December 31, 2018.

(4) Amounts reclassified from accumulated other comprehensive income (loss) for specifically identified cash flow hedges are included within interest expense in the consolidated statements of operations. The Company expects to reclassify approximately $14 million, net of tax, in net gains associated with its cash flow hedges into net income within the next 12 months.

(5) Amounts reclassified from accumulated other comprehensive loss for specifically identified pension and other postretirement benefits are included in other expense (income) in the consolidated statements of operations.

14. Earnings (Loss) Per Share

Earnings (loss) per share is computed using the two-class method. For periods in which the Company reports net income, diluted earnings per share is determined by using the weighted average number of common and dilutive common equivalent shares outstanding during the period, unless the effect is antidilutive. SARs and options to purchase 17 million shares of common stock were outstanding, but were excluded from the calculation of diluted earnings per share, for the year ended December 31, 2019 because the exercise prices of the SARs and options were greater than the average market price of the common shares and, therefore, the effect would be antidilutive. For the same reason, options to purchase 13 million and 10 million shares of common stock were outstanding, but were excluded from the calculation of diluted earnings per share, for the years ended December 31, 2018 and 2017, respectively. In addition, due to the loss from continuing operations attributable to CVS Health in the year ended December 31, 2018, 3 million potentially dilutive common equivalent shares were excluded from the calculation of diluted earnings per share, as the impact of these shares was antidilutive for that period.

The following is a reconciliation of basic and diluted earnings (loss) per share from continuing operations for the years ended December 31, 2019, 2018 and 2017:

In millions, except per share amounts	**2019**	**2018**	**2017**
Numerator for earnings (loss) per share calculation:			
Income (loss) from continuing operations	$ 6,631	$ (596)	$ 6,631
Income allocated to participating securities	(5)	(3)	(24)
Net (income) loss attributable to noncontrolling interests	3	2	(1)
Income (loss) from continuing operations attributable to CVS Health	$ 6,629	$ (597)	$ 6,606
Denominator for earnings (loss) per share calculation:			
Weighted average shares, basic	1,301	1,044	1,020
Effect of dilutive securities	4	—	4
Weighted average shares, diluted	1,305	1,044	1,024
Earnings (loss) per share from continuing operations:			
Basic	$ 5.10	$ (0.57)	$ 6.48
Diluted	$ 5.08	$ (0.57)	$ 6.45

15. Reinsurance

The Company utilizes reinsurance agreements primarily to: (a) reduce required capital and (b) facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit the Company to recover a portion of its losses from reinsurers, although they do not discharge the Company's primary liability as the direct insurer of the risks reinsured.

On November 30, 2018, the Company completed the sale of Aetna's standalone Medicare Part D prescription drug plans to a subsidiary of WellCare Health Plans, Inc. ("WellCare"), effective December 31, 2018. In connection with that sale, subsidiaries of WellCare and Aetna entered into reinsurance agreements under which WellCare ceded to Aetna 100% of the insurance risk related to the divested standalone Medicare Part D prescription drug plans for the 2019 PDP plan year.

In January 2020, the Company entered into two four-year reinsurance agreements with an unrelated reinsurer that allow it to reduce required capital and provide collateralized excess of loss reinsurance coverage on a portion of the Health Care Benefits segment's group Commercial Insured business.

Reinsurance recoverables (recorded as other current assets or other assets on the consolidated balance sheets) at December 31, 2019 and 2018 were as follows:

In millions	**2019**	**2018**
Reinsurer		
Hartford Life and Accident Insurance Company	$ 3,085	$ 3,470
Lincoln Life & Annuity Company of New York	413	424
WellCare Health Plans	355	—
VOYA Retirement Insurance and Annuity Company	175	186
All Other	103	461
Total	$ 4,131	$ 4,541

Prior to the Aetna Acquisition Date, the Company had no material assumed or ceded premiums or benefit costs. Accordingly, the Company has not provided disclosure of these amounts for periods prior to 2018.

Direct, assumed and ceded premiums earned for the years ended December 31, 2019 and 2018 were as follows:

In millions	**2019**	**2018**
Direct	$ 62,968	$ 8,365
Assumed	2,108	38
Ceded	(1,954)	(219)
Net premiums	$ 63,122	$ 8,184

The impact of reinsurance on benefit costs for the years ended December 31, 2019 and 2018 were as follows:

In millions	**2019**	**2018**
Direct	$ 52,592	$ 6,773
Assumed	1,562	32
Ceded	(1,625)	(211)
Net benefit costs	$ 52,529	$ 6,594

There is not a material difference between premiums on a written basis versus an earned basis.

The Company also has various agreements with unrelated reinsurers that do not qualify for reinsurance accounting under GAAP, and consequently are accounted for using deposit accounting. The Company entered into these contracts to reduce the risk of catastrophic loss which in turn reduces the Company's capital and surplus requirements. Total deposit assets and liabilities related to reinsurance agreements that do not qualify for reinsurance accounting under GAAP were not material as of December 31, 2019 or 2018.

16. Commitments and Contingencies

Guarantees

The Company has the following significant guarantee arrangements at December 31, 2019:

- ASC Claim Funding Accounts - The Company has arrangements with certain banks for the processing of claim payments for its ASC customers. The banks maintain accounts to fund claims of the Company's ASC customers. The customer is responsible for funding the amount paid by the bank each day. In these arrangements, the Company guarantees that the banks will not sustain losses if the responsible ASC customer does not properly fund its account. The aggregate maximum exposure under these arrangements is generally

limited to $250 million. The Company can limit its exposure to these guarantees by suspending the payment of claims for ASC customers that have not adequately funded the amount paid by the bank.

- Separate Accounts Assets - Certain Separate Accounts assets associated with the large case pensions business in the Corporate/Other segment represent funds maintained as a contractual requirement to fund specific pension annuities that the Company has guaranteed. Minimum contractual obligations underlying the guaranteed benefits in these Separate

Accounts were approximately $1.4 billion at both December 31, 2019 and 2018. See Note 1 "Significant Accounting Policies" for additional information on Separate Accounts. Contract holders assume all investment and mortality risk and are required to maintain Separate Accounts balances at or above a specified level. The level of required funds is a function of the risk underlying the Separate Account's investment strategy. If contract holders do not maintain the required level of Separate Accounts assets to meet the annuity guarantees, the Company would establish an additional liability. Contract holders' balances in the Separate Accounts at December 31, 2019 exceeded the value of the guaranteed benefit obligation. As a result, the Company was not required to maintain any additional liability for its related guarantees at December 31, 2019.

Lease Guarantees

Between 1995 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores and Linens 'n Things, each of which subsequently filed for bankruptcy, and Marshalls. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the former subsidiary's lease obligations for the initial lease term and any extension thereof pursuant to a renewal option provided for in the lease prior to the time of the disposition. When the subsidiaries were disposed of and accounted for as discontinued operations, the Company's guarantees remained in place, although each initial purchaser agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries fail to make the required payments under a store lease, the Company could be required to satisfy those obligations. As of December 31, 2019, the Company guaranteed 79 such store leases (excluding the lease guarantees related to Linens 'n Things, which have been recorded as a liability on the consolidated balance sheet), with the maximum remaining lease term extending through 2030.

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. The Company has recorded a liability for its estimated share of future assessments by applicable life and health guaranty associations. It is reasonably possible that in the future the Company may record a liability and expense relating to other insolvencies which could have a material adverse effect on the Company's operating results, financial condition and cash flows. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that limit future offsets.

HMOs in certain states in which the Company does business are subject to assessments, including market stabilization and other risk-sharing pools, for which the Company is assessed charges based on incurred claims, demographic membership mix and other factors. The Company establishes liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments the Company pays are dependent upon the Company's experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, the Company believes it has adequate reserves to cover such assessments.

The Company's total guaranty fund assessments liability was $84 million and $90 million at December 31, 2019 and 2018, respectively, and was recorded in accrued expenses on the consolidated balance sheets.

Litigation and Regulatory Proceedings

The Company is a party to numerous legal proceedings, investigations, audits and claims arising, for the most part, in the ordinary course of its businesses, including the matters described below. The Company records accruals for

outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company

evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and reasonably estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial condition.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. It is reasonably possible that the outcome of such legal matters could be material to the Company.

Usual and Customary Litigation

The Company is named as a defendant in a number of lawsuits that allege that the Company's retail stores overcharged for prescription drugs by not providing the correct usual and customary charge.

Corcoran et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of California) and *Podgorny* et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of Illinois). These putative class actions were filed against the Company in July and September 2015. The cases were consolidated in the U.S. District Court for the Northern District of California. Plaintiffs seek damages and injunctive relief under the consumer protection statutes of certain states on behalf of a class of consumers who purchased certain prescription drugs. Several third-party payors filed similar putative class actions on behalf of payors captioned *Sheet Metal Workers Local No. 20 Welfare and Benefit Fund v. CVS Health Corp.* and *Plumbers Welfare Fund, Local 130 v. CVS Health Corporation* (both pending in the U.S. District Court for the District of Rhode Island) in February and August 2016. In all of these cases the plaintiffs allege the Company overcharged for certain prescription drugs by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. In the *Corcoran* case, the U.S. District Court granted summary judgment to CVS on plaintiffs' claims in their entirety and certified certain subclasses in September 2017. In June 2019, the U.S. Court of Appeals for the Ninth Circuit reversed the U.S. District Court's grant of summary judgment and reversed the U.S. District Court's narrowing of the requested class. The *Corcoran* case is proceeding to a trial on a six state class basis, and trial is scheduled to occur in 2020. The *Sheet Metal Workers* plaintiffs have amended their complaint to assert a claim under the federal Racketeer Influenced and Corrupt Organizations Act premised on an alleged conspiracy between the Company and other PBMs. The Company is defending itself against these claims.

State of California ex rel. *Matthew Omlansky v. CVS Caremark Corporation* (Superior Court of the State of California, County of Sacramento). In April 2016, the California Superior Court unsealed a first amended *qui tam* complaint filed in July 2013. The government has declined to intervene in this case. The relator alleges that the Company submitted false claims for payment to the California Medicaid program in connection with reimbursement for drugs available through the CVS Health Savings Pass program as well as certain other generic drugs. The case has been stayed pending the relator's appeal of the judgment against him in a similar case against another retailer. The Company is defending itself against these claims.

State of Mississippi v. CVS Health Corporation, et al. (Circuit Court of DeSoto County, Mississippi, Third Judicial District). In July 2016, the Company was served with a complaint filed on behalf of the State of Mississippi. The complaint alleged that CVS retail pharmacies in Mississippi submitted false claims for reimbursement to the Mississippi Medicaid program by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. In June 2019, the Company's motion for judgment on the pleadings was granted in part and denied in part. Also in June 2019, the State of Mississippi's motion to dismiss the Company's counterclaim for declaratory relief was granted. The Company is defending itself against these claims.

PBM Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning its PBM practices.

Klein, et al. v. *Prime Therapeutics*, et al. (U.S. District Court for the District of Minnesota). This putative class action was filed against the Company and other PBMs in June 2017 on behalf of ERISA plan members who purchased and paid for EpiPen or EpiPen Jr. Plaintiffs allege that the PBMs are ERISA fiduciaries to plan members and have violated ERISA by allegedly causing higher inflated prices for EpiPens through the process of negotiating increased

rebates from EpiPen manufacturer Mylan. This case has been consolidated with a similar matter and is now proceeding as *In re EpiPen ERISA Litigation*. The Company is defending itself against these claims.

County of Harris, Texas v. Eli Lilly and Company, et al. (U.S. District Court for the Southern District of Texas). This lawsuit was filed against Caremark, Aetna, the manufacturers of insulin and other PBMs in November 2019 by Harris County. Harris County alleges that it was overcharged for insulin as a result of a "price fixing conspiracy" between the manufacturers and PBMs to artificially increase the price of insulin and other diabetes medications. The complaint alleges that the manufacturers and PBMs engaged in an "Insulin Pricing Scheme" whereby the manufacturers artificially increased the reported prices of their insulin products while "secretly" paying rebates to the PBMs in exchange for preferred treatment on the PBMs' drug formularies. The Company is defending itself against these claims.

In March 2017, Advanced Care Scripts, a subsidiary acquired in the Omnicare transaction that is now part of the Company's PBM specialty operations, received a subpoena from the U.S. Department of Justice (the "DOJ") requesting documents concerning its work with pharmaceutical manufacturers and charitable foundations that provide payment assistance to Medicare patients in connection with an investigation concerning potential violations of the federal Anti-Kickback Statute and/or federal False Claims Act. The Company has been cooperating with the government with respect to this subpoena and additional requests for information.

The Company has received subpoenas, CIDs and other requests for documents and information from, and is being investigated by, Attorneys General of several states regarding its PBM practices, including pricing and rebates. In addition, the Company has received inquiries from congressional committees regarding insulin pricing. The Company has been providing documents and information in response to these subpoenas, CIDs and requests for information.

Controlled Substances Litigation, Audits and Subpoenas

In December 2017, the U.S. Judicial Panel on Multidistrict Litigation consolidated numerous cases filed against various defendants by plaintiffs such as counties, cities, hospitals, Indian tribes and third-party payors, alleging claims generally concerning the impacts of widespread opioid abuse. The consolidated multidistrict litigation captioned *In re National Prescription Opiate Litigation* (MDL No. 2804) is pending in the U.S. District Court for the Northern District of Ohio. This multidistrict litigation presumptively includes hundreds of relevant federal court cases that name the Company as a defendant. A significant number of similar cases that name the Company as a defendant in some capacity are pending in state courts. In addition, the Company has been named as a defendant in similar cases brought by certain state Attorneys General. The Company is defending itself against all such claims. Additionally, the Company has received subpoenas, CIDs and/or other requests for information regarding opioids from state Attorneys General and insurance and other regulators of several states. The Company has been cooperating with the government with respect to these subpoenas, CIDs and other requests for information.

The Company routinely is audited by the U.S. Drug Enforcement Administration (the "DEA"). In some instances, the Company is in discussions with the DEA and U.S. Attorney's Offices concerning allegations that the Company violated certain requirements of the federal Controlled Substances Act.

In September 2015, the DEA served the Company with an administrative subpoena. The subpoena seeks documents related to controlled substance policies, procedures and practices at eight Omnicare pharmacy locations from May 2012 to the present. In September 2017, the DEA expanded the investigation to include an additional Omnicare pharmacy location. The Company has been cooperating with the government and providing documents and witnesses in response to this subpoena.

In January 2020, the DOJ served the Company with a DEA administrative subpoena. The subpoena seeks documents relating to practices with respect to opioids and other controlled substances at CVS Pharmacy locations in connection with an investigation concerning potential violations of the federal Controlled Substances Act and the federal False Claims Act. The Company has been cooperating with the government with respect to this subpoena.

Prescription Processing Litigation and Investigations

U.S. ex rel. *Bassan* et al. *v. Omnicare, Inc. and CVS Health Corp.* and *U.S.* ex rel. *Mohajer* et al. *v. Omnicare, Inc. and CVS Health Corp.* (U.S. District Court for the Southern District of New York). In December 2019, the U.S. Attorney's Office for the Southern District of New York (the "SDNY") filed complaints-in-intervention in these two previously sealed *qui tam* cases. With respect to the *Bassan* complaint, all states except Washington, D.C. and Indiana have declined to intervene; Washington, D.C. has intervened, and Indiana has not filed a decision on intervention. The government's investigation related to these complaints included the previously disclosed CID that

the Company received in October 2015 from the SDNY concerning the Company's Omnicare pharmacies' cycle fill process for assisted living facilities. The complaints allege that for certain non-skilled nursing facilities,

Omnicare improperly filled prescriptions beyond one year where a valid prescription did not exist and that these dispensing events violated the federal False Claims Act. The Company is defending itself against these claims.

In July 2017, the Company also received a subpoena from the California Department of Insurance requesting documents concerning the Company's Omnicare pharmacies' cycle fill process for assisted living facilities. The Company has been cooperating with the California Department of Insurance and providing documents and information in response to this subpoena.

In December 2016, the Company received a CID from the U.S. Attorney's Office for the Northern District of New York requesting documents and information in connection with a federal False Claims Act investigation concerning whether the Company's retail pharmacies improperly submitted certain insulin claims to Part D of the Medicare program rather than Part B of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to this CID.

In May 2017, the Company received a CID from the SDNY requesting documents and information concerning possible false claims submitted to Medicare in connection with reimbursements for prescription drugs under the Medicare Part D program. The Company has been cooperating with the government and providing documents and information in response to this CID.

Provider Proceedings

The Company is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by health care providers with whom the Company has a contract and with whom the Company does not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that the Company paid too little to its health plan members and/or providers for these services and/or otherwise allege that the Company failed to timely or appropriately pay or administer claims and benefits (including the Company's post payment audit and collection practices and reductions in payments to providers due to sequestration). Other major health insurers are the subject of similar litigation or have settled similar litigation.

The Company also has received subpoenas and/or requests for documents and other information from, and been investigated by, state Attorneys General and other state and/or federal regulators, legislators and agencies relating to, and the Company is involved in other litigation regarding, its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against the Company with respect to its out-of-network benefit payment and/or administration practices.

CMS Actions

CMS regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to the Company's and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. The Company collects claim and encounter data from providers and generally relies on providers to appropriately code their submissions to the Company and document their medical records, including the diagnosis data submitted to the Company with claims. CMS pays increased premiums to Medicare Advantage plans and Medicare PDP plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to the Company. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require the Company to refund premium payments if the Company's risk adjusted premiums are not properly supported by medical record data. The Office of the Inspector General of Health and Human Services (the "OIG") also is auditing the Company's risk adjustment-related data and that of other companies. The Company expects CMS and the OIG to continue these types of audits.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will extrapolate the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments

made under the contract being audited. For contract years prior to 2011, CMS did not extrapolate sample error rates to the entire contract. As a result, the revised methodology may increase the Company's exposure to premium refunds to CMS based on incomplete medical records

maintained by providers. Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various contract years for RADV audit, and the number of RADV audits continues to increase. The Company is currently unable to predict which of its Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to the Company, the effect of any such refunds or adjustments on the actuarial soundness of the Company's Medicare Advantage bids, or whether any RADV audit findings would require the Company to change its method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in the Company's bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, the U.S. Department of Health and Human Services or otherwise, including audits of the Company's minimum MLR rebates, methodology and/or reports, could be material and could adversely affect the Company's operating results, financial condition and/or cash flows.

Medicare CIDs

The Company has received CIDs from the Civil Division of the DOJ in connection with a current investigation of the Company's patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

Stockholder Matters

The Company and/or its current and/or former directors and/or executive officers are named as defendants in a number of lawsuits and a request for access to information initiated by holders or putative holders of CVS Health common stock.

Between February and August 2019, six class action complaints were filed by putative plaintiffs against the Company and certain current and former officers and directors: *Anarkat v. CVS Health Corp*., et al. (U.S. District Court for the District of Rhode Island); *Labourers' Pension Fund of Central and Eastern Canada v. CVS Health Corp.*, et al. (New York Supreme Court); *City of Warren Police and Fire Retirement Sys.v. CVS Health Corp.*, et. al. (Rhode Island Superior Court); *Cambria Co. Employees Retirement Sys. v. CVS Health Corp.*, et al. (New York Supreme Court); *Freundlich v. CVS Health Corp.*, et al. (Rhode Island Superior Court); and *Waterford Twp. Police & Fire Retirement Sys. v. CVS Health Corp.*, et al. (U.S. District Court for the District of Rhode Island). The plaintiffs in these cases assert a variety of causes of action under federal securities laws that are premised on allegations that the defendants made certain omissions and misrepresentations relating to the performance of the Company's LTC business unit, which allegedly injured investors who acquired CVS Health securities between February 9, 2016 and February 20, 2019. The *Freundlich* case also alleges that defendants misrepresented anticipated synergies of the Aetna Acquisition. Plaintiffs in the *Freundlich* and the *City of Warren* cases have filed a consolidated complaint that combines their allegations. The Company is defending itself against these claims.

In January 2020*,* a derivative complaint was filed against the Company's directors and current and former executive officers in the U.S. District Court for the District of Rhode Island by a stockholder. *Lovoi v. Aguirre,* et al. makes allegations similar to those contained the six stockholder class action complaints described above, including that the Company made false or misleading statements about its LTC business unit's financial health. The *Lovoi* complaint alleges claims for breach of fiduciary duty against the Company's directors and certain of its current and former executive officers and for violation of the federal securities laws. The *Lovoi* complaint seeks damages, restitution and equitable relief on behalf of the Company. The Company's directors and current and former executive officers are defending themselves against these claims.

In November 2019, the Company received a demand to inspect its books and records under Delaware General Corporation Law Section 220 from purported stockholder Judith B. Cohen. The demand seeks various documents related to the Company's LTC operations, its financial condition and its goodwill impairment charges, as well as more general information regarding share repurchases, director nominations and charitable donations. The Company has objected to this request.

Other Legal and Regulatory Proceedings.

The Company is also a party to other legal proceedings and is subject to government investigations, inquiries and audits and has received and is cooperating with the government in response to CIDs, subpoenas or similar process

from various governmental agencies requesting information, arising, for the most part, in the ordinary course of its businesses. These other legal proceedings and government actions include claims of or relating to bad faith, medical or professional malpractice, claims processing, dispensing of medications, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits, provider network structure (including the use of performance-

based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure or use of personal information, anticompetitive practices, general contractual matters, product liability, intellectual property litigation and employment litigation. Some of these other legal proceedings are or are purported to be class actions or derivative claims. The Company is defending itself against the claims brought in these matters.

Awards to the Company and others of certain government contracts, particularly Medicaid contracts and other contracts with government customers in the Company's Health Care Benefits segment, frequently are subject to protests by unsuccessful bidders. These protests may result in awards to the Company being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect the Company's operating results. The Company will continue to defend contract awards it receives.

There also continues to be a heightened level of review and/or audit by regulatory authorities and legislators of, and increased litigation regarding, the Company's and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including manufacturers' rebates, pricing, the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health care company, the Company regularly is the subject of government actions of the types described above. These government actions may prevent or delay the Company from implementing planned premium rate increases and may result, and have resulted, in restrictions on the Company's businesses, changes to or clarifications of the Company's business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to the Company by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

The Company can give no assurance that its businesses, financial condition, operating results and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state government investigations of one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

17. Segment Reporting

The Company has three operating segments, Pharmacy Services, Retail/LTC and Health Care Benefits, as well as a Corporate/Other segment. The Company's segments maintain separate financial information, and the CODM evaluates the segments' operating results on a regular basis in deciding how to allocate resources among the segments and in assessing segment performance. The CODM evaluates the performance of the Company's segments based on adjusted operating income. Effective for the first quarter of 2019, adjusted operating income is defined as operating income (GAAP measure) excluding the impact of amortization of intangible assets and other items, if any, that neither relate to the ordinary course of the Company's business nor reflect the Company's underlying business performance. Segment financial information has been retrospectively adjusted to conform with the current period presentation. See the reconciliation of consolidated operating income (GAAP measure) to adjusted operating income below for further context regarding the items excluded from operating income in determining adjusted operating income. The Company uses adjusted operating income as its principal measure of segment performance as it enhances the Company's ability to compare past financial performance with current performance and analyze underlying business performance and trends. Non-GAAP financial measures the Company discloses, such as

consolidated adjusted operating income, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

Effective for the first quarter of 2019, the Company realigned the composition of its segments to correspond with changes to its operating model and reflect how its CODM reviews information and manages the business. See Note 1 "Significant Accounting Policies" for further discussion of this realignment. Segment financial information has been retrospectively adjusted to reflect these changes.

In 2018 and 2017, approximately 9.8% and 12.3%, respectively, of the Company's consolidated revenues were from Aetna, a Pharmacy Services segment client. On November 28, 2018, the Company completed the Aetna Acquisition. Subsequent to the Aetna Acquisition, transactions with Aetna continue to be reported within the Pharmacy Services segment, but are eliminated in the Company's consolidated financial statements.

In millions	**Pharmacy Services [1]**	**Retail/ LTC**	**Health Care Benefits**	**Corporate/ Other**	**Intersegment Eliminations [2]**	**Consolidated Totals**
2019:						
Revenues from customers	$ 141,491	$ 86,608	$ 69,005	$ 100	$ (41,439)	$ 255,765
Net investment income	—	—	599	412	—	1,011
Total revenues	141,491	86,608	69,604	512	(41,439)	256,776
Adjusted operating income (loss)	5,129	6,705	5,202	(1,000)	(697)	15,339
Depreciation and amortization	766	1,723	1,721	161	—	4,371
Additions to property and equipment	332	1,212	533	404	—	2,481
2018:						
Revenues from customers	134,736	83,989	8,904	4	(33,714)	193,919
Net investment income	—	—	58	602	—	660
Total revenues	134,736	83,989	8,962	606	(33,714)	194,579
Adjusted operating income (loss)	4,955	7,403	528	(856)	(769)	11,261
Depreciation and amortization	710	1,698	172	138	—	2,718
Additions to property and equipment	326	1,350	46	401	—	2,123
2017:						
Revenues from customers	130,822	79,398	3,582	—	(29,037)	184,765
Net investment income	—	—	5	16	—	21
Total revenues	130,822	79,398	3,587	16	(29,037)	184,786
Adjusted operating income (loss)	4,628	7,475	359	(896)	(741)	10,825
Depreciation and amortization	710	1,651	2	116	—	2,479
Additions to property and equipment	311	1,398	—	340	—	2,049

(1) Total revenues of the Pharmacy Services segment include approximately $11.5 billion, $11.4 billion and $10.8 billion of retail co-payments for 2019, 2018 and 2017, respectively. See Note 1 "Significant Accounting Policies" for additional information about retail co-payments.

(2) Intersegment eliminations relate to intersegment revenue generating activities that occur between the Pharmacy Services segment, the Retail/LTC segment and/or the Health Care Benefits segment.

The following is a reconciliation of consolidated operating income to adjusted operating income for the years ended December 31, 2019, 2018 and 2017:

In millions	**2019**	**2018**	**2017**
Operating income (GAAP measure)	$ 11,987	$ 4,021	$ 9,538
Amortization of intangible assets (1)	2,436	1,006	817
Acquisition-related transaction and integration costs (2)	480	492	65
Store rationalization charges (3)	231	—	215
Loss on divestiture of subsidiary (4)	205	86	9
Goodwill impairments (5)	—	6,149	181
Impairment of long-lived assets (6)	—	43	—
Interest income on financing for the Aetna Acquisition (7)	—	(536)	—
Adjusted operating income	$ 15,339	$ 11,261	$ 10,825

(1) The Company's acquisition activities have resulted in the recognition of intangible assets as required under the acquisition method of accounting which consist primarily of trademarks, customer contracts/relationships, covenants not to compete, technology, provider networks and value of business acquired. Definite-lived intangible assets are amortized over their estimated useful lives and are tested for impairment when events indicate that the carrying value may not be recoverable. The amortization of intangible assets is reflected in the Company's statements of operations in operating expenses within each segment. Although intangible assets contribute to the Company's revenue generation, the amortization of intangible assets does not directly relate to the underwriting of the Company's insurance products, the services performed for the Company's customers or the sale of the Company's products or services. Additionally, intangible asset amortization expense typically fluctuates based on the size and timing of the Company's acquisition activity. Accordingly, the Company believes excluding the amortization of intangible assets enhances the Company's and investors' ability to compare the Company's past financial performance with its current performance and to analyze underlying business performance and trends. Intangible asset amortization excluded from the related non-GAAP financial measure represents the entire amount recorded within the Company's GAAP financial statements, and the revenue generated by the associated intangible assets has not been excluded from the related non-GAAP financial measure. Intangible asset amortization is excluded from the related non-GAAP financial measure because the amortization, unlike the related revenue, is not affected by operations of any particular period unless an intangible asset becomes impaired or the estimated useful life of an intangible asset is revised.

(2) In 2019, 2018 and 2017, acquisition-related transaction and integration costs relate to the Aetna Acquisition. In 2018 and 2017, acquisition-related transaction and integration costs also relate to the acquisition of Omnicare. The acquisition-related transaction and integration costs are reflected in the Company's consolidated statements of operations in operating expenses within the Corporate/Other segment and the Retail/LTC segment.

(3) In 2019, the store rationalization charges relate to the planned closure of 46 underperforming retail pharmacy stores during the second quarter of 2019 and the planned closure of 22 underperforming retail pharmacy stores during the first quarter of 2020. In 2019, the store rationalization charges primarily relate to operating lease right-of-use asset impairment charges and are reflected in the Company's consolidated statements of operations in operating expenses within the Retail/LTC segment. In 2017, the store rationalization charges related to the Company's enterprise streamlining initiative and are reflected in the Company's consolidated statements of operations in operating expenses within the Retail/LTC segment.

(4) In 2019, the loss on divestiture of subsidiary represents the pre-tax loss on the sale of Onofre, which occurred on July 1, 2019. The loss on divestiture primarily relates to the elimination of the cumulative translation adjustment from accumulated other comprehensive income. In 2018, the loss on divestiture of subsidiary represents the pre-tax loss on the sale of the Company's RxCrossroads subsidiary for $725 million on January 2, 2018. In 2017, the loss on divestiture of subsidiary represents transaction costs associated with the sale of RxCrossroads. The losses on divestiture of subsidiary are reflected in the Company's consolidated statements of operations in operating expenses within the Retail/LTC segment and Corporate/Other segment.

(5) In 2018, the goodwill impairments relate to the LTC reporting unit within the Retail/LTC segment. In 2017, the goodwill impairments relate to the RxCrossroads reporting unit within the Retail/LTC segment.

(6) In 2018, impairment of long-lived assets primarily relates to the impairment of property and equipment within the Retail/LTC segment and is reflected in operating expenses in the Company's consolidated statements of operations.

(7) In 2018, the Company recorded interest income of $536 million on the proceeds of the $40 billion of unsecured senior notes it issued in March 2018 to partially fund the Aetna Acquisition. All amounts are for the periods prior to the close of the Aetna Acquisition, which occurred on November 28, 2018, and were recorded within the Corporate/Other segment.

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of CVS Health Corporation

Opinion on Internal Control over Financial Reporting

We have audited CVS Health Corporation's internal control over financial reporting as of December 31, 2019, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, CVS Health Corporation (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2019, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the 2019 consolidated financial statements of the Company and our report dated February 18, 2020, expressed an unqualified opinion thereon.

Basis for Opinion

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

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

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

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ Ernst & Young LLP
Boston, Massachusetts
February 18, 2020

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of CVS Health Corporation

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of CVS Health Corporation (the Company) as of December 31, 2019 and 2018, the related consolidated statements of operations, comprehensive income (loss), shareholders' equity and cash flows for each of the three years in the period ended December 31, 2019, and the related notes (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2019 and 2018, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2019, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2019, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated February 18, 2020 expressed an unqualified opinion thereon.

Adoption of ASU 2016-02

As discussed in Note 1 to the consolidated financial statements, the Company changed its method of accounting for leases in 2019 due to the adoption of ASU 2016-02, *Leases*.

Basis for Opinion

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

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

Critical Audit Matters

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

Impairment of goodwill

Description of the Matter

At December 31, 2019, the Company's goodwill allocated to the Long-term Care ("LTC") and Commercial Business reporting units was $0.4 billion and $26.8 billion, respectively. As discussed in Note 1 to the consolidated financial statements, goodwill is not amortized, but rather is subject to an annual impairment review, or more frequent reviews, if events and circumstances indicate an impairment exists.

Auditing management's annual goodwill impairment test related to the LTC and Commercial Business reporting units was complex and highly judgmental due to the significant estimation required to determine the fair value of the reporting units. In particular, the fair value estimate was sensitive to significant assumptions, such as changes in the discount rate, projected revenue and projected operating income that are forward-looking and affected by future economic and market conditions.

How We Addressed the Matter in Our Audit

We obtained an understanding, evaluated the design and tested the operating effectiveness of controls over the Company's annual goodwill impairment review process, including controls over management's review of the significant assumptions described above.

To test the estimated fair value of the LTC and Commercial Business reporting units, we performed audit procedures that included, among others, assessing methodologies and testing the significant assumptions discussed above and the underlying data used by the Company in its analysis. We compared the significant assumptions to the reporting units' historical results and third-party industry data. We performed sensitivity analyses of significant assumptions to evaluate the changes in the fair value of the reporting units that would result from changes in the key assumptions. We involved valuation specialists to assist in our assessment of the methodology and significant assumptions (such as discount rates), used by the Company. In addition, we tested management's reconciliation of the fair value of all reporting units to the market capitalization of the Company.

Valuation of health care costs payable

Description of the Matter

At December 31, 2019, the incurred but not reported ("IBNR") liabilities represented $5.0 billion of $6.9 billion of health care costs payable. As discussed in Note 1 to the financial statements, the Company's liability for health care costs payable includes estimated payments for (1) services rendered to members but not yet reported and (2) claims that have been reported but not yet paid, each as of the financial statement date (collectively, "IBNR"). The estimated IBNR liability is developed utilizing actuarial principles and assumptions that include historical and projected claim submission and processing patterns, historical and assumed medical cost trends, historical utilization of medical services, claim inventory levels, changes in membership and product mix, seasonality and other relevant factors to record the actuarial best estimate of health care costs payable. There is significant uncertainty inherent in determining management's actuarial best estimate of health care costs payable. In particular, the estimate is sensitive to the assumed completion factors and the assumed health care cost trend rates.

Auditing management's actuarial best estimate of IBNR reserves for health care costs payable for its products and services involved a high degree of subjectivity in evaluating management's assumptions used in the valuation process.

How We Addressed the Matter in Our Audit

We obtained an understanding, evaluated the design and tested the operating effectiveness of controls over the process for estimating IBNR reserves. This included, among others, controls over the completeness and accuracy of data used in the actuarial projections, the transfer of data between underlying source systems, and the review and approval processes that management has in place for the actuarial principles and assumptions used in estimating the health care costs payable.

To test IBNR reserves, our audit procedures included, among others, testing the completeness and accuracy of the underlying claim and membership data used in the calculation of IBNR reserves. We involved actuarial specialists to assist with our audit procedures, which included, among others, evaluating the methodologies applied by the Company in determining the actuarially determined liability, evaluating management's actuarial principles and assumptions used in their analysis based on historical claim experience, and independently calculating a range of reserve estimates for comparison to management's actuarial best estimate of the liability for health care costs payable. Additionally, we performed a review of the prior period liabilities for incurred but not paid claims to subsequent claims development.

/s/ Ernst & Young LLP

We have served as the Company's auditor since 2007.

Boston, Massachusetts
February 18, 2020

Quarterly Financial Information (Unaudited)

In millions, except per share amounts	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Year
2019:					
Total revenues	$ 61,646	$ 63,431	$ 64,810	$ 66,889	$ 256,776
Operating income	2,690	3,332	2,928	3,037	11,987
Income from continuing operations	1,427	1,931	1,529	1,744	6,631
Net income attributable to CVS Health	1,421	1,936	1,530	1,747	6,634
Per common share data:					
Basic earnings per common share:					
Income from continuing operations attributable to CVS Health	$ 1.09	$ 1.49	$ 1.17	$ 1.34	$ 5.10
Income from discontinued operations attributable to CVS Health	$ —	$ —	$ —	$ —	$ —
Net income attributable to CVS Health	$ 1.09	$ 1.49	$ 1.17	$ 1.34	$ 5.10
Diluted earnings per common share:					
Income from continuing operations attributable to CVS Health	$ 1.09	$ 1.49	$ 1.17	$ 1.33	$ 5.08
Income from discontinued operations attributable to CVS Health	$ —	$ —	$ —	$ —	$ —
Net income attributable to CVS Health	$ 1.09	$ 1.49	$ 1.17	$ 1.33	$ 5.08
Dividends per common share	$ 0.50	$ 0.50	$ 0.50	$ 0.50	$ 2.00

In millions, except per share amounts	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Year
2018:					
Total revenues	$ 45,743	$ 46,922	$ 47,490	$ 54,424	$ 194,579
Operating income (loss)	1,996	(1,373)	2,574	824	4,021
Income (loss) from continuing operations	998	(2,562)	1,390	(422)	(596)
Net income (loss) attributable to CVS Health	998	(2,563)	1,390	(419)	(594)
Per common share data:					
Basic earnings (loss) per common share:					
Income (loss) from continuing operations attributable to CVS Health	$ 0.98	$ (2.52)	$ 1.36	$ (0.37)	$ (0.57)
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ —	$ —	$ —	$ —
Net income (loss) attributable to CVS Health	$ 0.98	$ (2.52)	$ 1.36	$ (0.37)	$ (0.57)
Diluted earnings (loss) per common share:					
Income (loss) from continuing operations attributable to CVS Health	$ 0.98	$ (2.52)	$ 1.36	$ (0.37)	$ (0.57)
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ —	$ —	$ —	$ —
Net income (loss) attributable to CVS Health	$ 0.98	$ (2.52)	$ 1.36	$ (0.37)	$ (0.57)
Dividends per common share	$ 0.50	$ 0.50	$ 0.50	$ 0.50	$ 2.00

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

None.

Item 9A. Controls and Procedures.

Evaluation of disclosure controls and procedures

The Company's Chief Executive Officer and Chief Financial Officer, after evaluating the effectiveness of the design and operation of the Company's disclosure controls and procedures (as defined in Rules 13a-15 (f) and 15d-15(f) under the Securities Exchange Act of 1934) as of December 31, 2019, have concluded that as of such date the Company's disclosure controls and procedures were adequate and effective at a reasonable assurance level and designed to ensure that material information relating to the Company and its consolidated subsidiaries would be made known to such officers on a timely basis.

Management's report on internal control over financial reporting

Management is responsible for establishing and maintaining adequate internal control over financial reporting. The Company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of the Company's consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the Company's assets that could have a material effect on the Company's consolidated financial statements. In order to ensure the Company's internal control over financial reporting is effective, management regularly assesses such control and did so most recently for its financial reporting as of December 31, 2019.

Management conducted an assessment of the effectiveness of the Company's internal control over financial reporting based on the criteria established in *Internal Control-Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 Framework). This evaluation included review of the documentation, evaluation of the design effectiveness and testing of the operating effectiveness of controls. The Company's system of internal control over financial reporting is enhanced by periodic reviews by the Company's internal auditors, written policies and procedures and a written Code of Conduct adopted by CVS Health's Board of Directors, applicable to all employees of the Company. In addition, the Company has an internal Disclosure Committee, comprised of management from each functional area within the Company, which performs a separate review of disclosure controls and procedures. There are inherent limitations in the effectiveness of any system of internal control over financial reporting.

Based on management's assessment, management concluded that the Company's internal control over financial reporting is effective and provides reasonable assurance that assets are safeguarded and that the financial records are reliable for preparing financial statements as of December 31, 2019.

Ernst & Young LLP, the Company's independent registered public accounting firm, is appointed by CVS Health's Board of Directors and ratified by CVS Health's stockholders. They were engaged to render an opinion regarding the fair presentation of the Company's consolidated financial statements as well as conducting an audit of internal control over financial reporting. Their reports included in Item 8 of this Form 10-K are based upon audits conducted in accordance with the standards of the Public Company Accounting Oversight Board (United States).

Changes in internal control over financial reporting

On November 28, 2018, the Company completed its acquisition of Aetna. During the fourth quarter ended December 31, 2019, the Company completed the process of integrating the internal control over financial reporting of Aetna with the rest of the Company.

Other than the foregoing, there has been no change in the Company's internal control over financial reporting identified in connection with the evaluation required by paragraph (d) of Rule 13a-15 or Rule 15d-15 that occurred

during the fourth quarter ended December 31, 2019 that has materially affected, or is reasonably likely to materially affect, the Company's internal control over financial reporting.

Item 9B. Other Information.

No events have occurred during the fourth quarter ended December 31, 2019 that would require disclosure under this item.

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

Information concerning the Executive Officers of CVS Health Corporation is included in Part I of this 10-K pursuant to General Instruction G to Form 10-K.

The sections of the Proxy Statement under the captions "Committees of the Board as of the Annual Meeting," "Code of Conduct," "Audit Committee Report," and "Biographies of our Incumbent Board Nominees" are incorporated herein by reference.

Item 11. Executive Compensation.

The sections of the Proxy Statement under the captions "Non-Employee Director Compensation" and "Executive Compensation and Related Matters," including "Letter from the Management Planning and Development Committee," "Compensation Committee Report," "Compensation Discussion and Analysis" and "Compensation of Named Executive Officers" are incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

The sections of the Proxy Statement under the captions "Share Ownership of Directors and Certain Executive Officers" and "Share Ownership of Principal Stockholders" are incorporated herein by reference. Those sections contain information concerning security ownership of certain beneficial owners and management and related stockholder matters.

The following table summarizes information about the registrants common stock that may be issued upon the exercise of options, warrants and rights under all of the Company's equity compensation plans as of December 31, 2019:

	Number of securities to be issued upon exercise of outstanding options, warrants and rights [1] [2] (a)	Weighted average exercise price of outstanding options, warrants and rights (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in first column) [1] (c)
Equity compensation plans approved by stockholders [3]	32,237	$ 73.32	17,152
Equity compensation plans not approved by stockholders [4] [5]	4,518	43.46	26,849
Total	36,755	$ 71.83	44,001

(1) Shares in thousands.

(2) Consists of: (i) 21,184 shares of common stock underlying outstanding options, (ii) 1,110 shares of common stock issuable upon the exercise of outstanding stock appreciation rights ("SARs") and (iii) 14,461 shares of common stock issuable on the vesting of outstanding restricted stock units, deferred stock units and performance stock units, assuming target level performance in the case of performance stock units. The number of shares included with respect to outstanding SARs is the number of shares of CVS Health common stock that would have been issued had the SARs been exercised based on the closing price per share of CVS Health common stock on December 31, 2019, as reported on the NYSE, which was $74.29.

(3) Consists of the CVS Health 2017 Incentive Compensation Plan.

(4) Consists of the Amended Aetna Inc. 2010 Stock Incentive Plan (the "Aetna Stock Plan").

(5) Amount in column (c) consists of the maximum number of shares of CVS Health common stock available for future issuance under the Aetna Stock Plan as of December 31, 2019.

The Aetna Stock Plan was last approved by Aetna's shareholders at Aetna's 2017 Annual Meeting on May 19, 2017. The Company elected to continue to grant awards under the Aetna Stock Plan to employees of Aetna and its subsidiaries following the completion of the Aetna Acquisition. The Aetna Stock Plan is designed to promote the Company's interests and those of its stockholders and to further align the interests of stockholders and employees by tying awards to total return to stockholders, enabling plan participants to acquire additional equity interests in the Company and providing compensation opportunities

dependent upon the Company's performance. The Aetna Stock Plan has not been submitted to the Company's stockholders and will expire on May 21, 2020.

Under the Aetna Stock Plan, eligible participants can be granted stock options to purchase shares of CVS Health common stock, SARs, time-vesting and/or performance-vesting incentive stock or incentive units and other stock based awards. As of December 31, 2019, the maximum number of shares of CVS Health common stock that may be issued under the awards outstanding under the Aetna Stock Plan was 4.5 million shares, subject to adjustment for corporate transactions and 26.8 million shares remained available for future awards. If an award under the Aetna Stock Plan is paid solely in cash, no shares are deducted from the number of shares available for issuance under the Aetna Stock Plan.

Item 13. Certain Relationships and Related Transactions, and Director Independence.

The sections of the Proxy Statement under the captions "Independence Determinations for Directors" and "Related Person Transaction Policy" are incorporated herein by reference.

Item 14. Principal Accountant Fees and Services.

The section of the Proxy Statement under the caption "Item 2: Ratification of Appointment of Independent Registered Public Accounting Firm for 2020" is incorporated herein by reference.

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PART IV

Item 15. Exhibits, Financial Statement Schedules.

The following documents are filed as part of this 10-K:

1. Financial Statements. See "Index to Consolidated Financial Statements" in Item 8 of this 10-K.

2. Financial Statement Schedules. All financial statement schedules are omitted because they are not applicable, not required under the instructions, or the information is included in the consolidated financial statements or related notes.

3. Exhibits. The exhibits listed in the "Index to Exhibits" in this Item 15 are filed or incorporated by reference as part of this 10-K. Exhibits marked with an asterisk (*) are management contracts or compensatory plans or arrangements. Exhibits other than those listed are omitted because they are not required to be listed or are not applicable. Pursuant to Item 601(b)(4)(iii) of Regulation S-K, the Registrant hereby agrees to furnish to the Securities and Exchange Commission a copy of any omitted instrument that is not required to be listed.

INDEX TO EXHIBITS

Exhibit	Description
2	**Plan of acquisition, reorganization, arrangement, liquidation or succession**
2.1	Agreement and Plan of Merger, dated as of May 20, 2015, among CVS Pharmacy, Inc., Tree Merger Sub, Inc. and Omnicare, Inc. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K filed May 21, 2015).
2.2	Master Transaction Agreement dated as of October 22, 2017, by and between Aetna Inc. and Hartford Life and Accident Insurance Company (incorporated by reference to Exhibit 2.3 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
2.3	Agreement and Plan of Merger, dated as of December 3, 2017, among CVS Health Corporation, Hudson Merger Sub Corp. and Aetna Inc. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K filed December 5, 2017).
3	**Articles of Incorporation and Bylaws**
3.1	Restated Certificate of Incorporation of the Registrant dated June 4, 2018 (incorporated by reference to Exhibit 3.1C of Registrant's Current Report on Form 8-K filed June 5, 2018).
3.2	By-Laws of the Registrant, as amended and restated June 4, 2018 (incorporated by reference to Exhibit 3.2 to the Registrant's Current Report on Form 8-K filed June 5, 2018).
4	**Instruments defining the rights of security holders, including indentures**
4.1	Specimen common stock certificate (incorporated by reference to Exhibit 4.1 to the Registration Statement of the Registrant ((then known as CVS Corporation) as successor to Melville Corporation) on Form 8-B filed November 4, 1996).
4.2	Senior Indenture dated August 15, 2006, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed August 15, 2006).
4.3	Form of the Registrant's 2020 Floating Rate Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.4	Form of the Registrant's 2021 Floating Rate Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.5	Form of the Registrant's 2020 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.6	Form of the Registrant's 2021 Note (incorporated by reference to Exhibit 4.4 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.7	

	Form of the Registrant's 2023 Note (incorporated by reference to Exhibit 4.5 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.8	Form of the Registrant's 2025 Note (incorporated by reference to Exhibit 4.6 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.9	Form of the Registrant's 2028 Note (incorporated by reference to Exhibit 4.7 to the Registrant's Current Report on Form 8-K filed March 12, 2018).

4.10	Form of the Registrant's 2038 Note (incorporated by reference to Exhibit 4.8 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.11	Form of the Registrant's 2048 Note (incorporated by reference to Exhibit 4.9 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.12	Form of the Registrant's 2024 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed August 15, 2019).
4.13	Form of the Registrant's 2026 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed August 15, 2019).
4.14	Form of the Registrant's 2029 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed August 15, 2019).
4.15	Material terms of outstanding securities that are registered under Section 12 of the 1934 Act as required by Item 202(a)-(d) and (f) of Regulation S-K.
10	**Material Contracts**
10.1	Five Year Credit Agreement, dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017).
10.2	Amendment No. 1 to Five Year Credit Agreement dated as of December 15, 2017, to the Five Year Credit Agreement dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.3 to the Registrant's Current Report on Form 8-K filed December 19, 2017).
10.3	Amendment No. 2 to Five Year Credit Agreement dated as of May 17, 2018, to the Five Year Credit Agreement dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018).
10.4	Amendment No. 3, dated as of May 16, 2019, to the Five Year Credit Agreement dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.4 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.5	Five Year Credit Agreement dated as of May 17, 2018, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018).
10.6	Amendment No. 1, dated as of May 16, 2019, to the Five Year Credit Agreement dated as of May 17, 2018, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.3 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.7	364-Day Credit Agreement dated as of May 16, 2019 by and among the Registrant, the lenders party thereto and Bank of America, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.8	Five Year Credit Agreement dated as of May 16, 2019 by and among the Registrant, the lenders party thereto and Bank of America, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.2 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.9*	The Registrant's Supplemental Retirement Plan I for Select Senior Management, as amended and restated as of December 31, 2008 (incorporated by reference to Exhibit 10.6 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2009).
10.10*	Form of Enterprise Non-Competition, Non-Disclosure and Developments Agreement between the Registrant and certain of the Registrant's executive officers (incorporated by reference to Exhibit 10.25 of the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013).
10.11*	The Registrant's Deferred Stock Compensation Plan, as amended and restated.
10.12*	The Registrant's 2007 Employee Stock Purchase Plan, as amended (incorporated by reference to Exhibit 10.20 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
10.13*	Universal 409A Definition Document, as amended (incorporated by reference to Exhibit 10.28 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
10.14*	The Registrant's Deferred Compensation Plan, as amended and restated.
10.15*	

	The Registrant's Partnership Equity Program, as amended (incorporated by reference to Exhibit 10.25 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.16*	The Registrant's Performance-Based Restricted Stock Unit Plan, as amended (incorporated by reference to Exhibit 10.27 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).

10.17*	The Registrant's 2017 Incentive Compensation Plan (incorporated by reference to Exhibit A to the Registrant's Definitive Proxy Statement on Form 14A filed March 31, 2017).
10.18*	The Registrant's Executive Incentive Plan, as amended (incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017).
10.19*	The Registrant's Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017).
10.20*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.29 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.21*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.30 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.22*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.23*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax) (incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.24*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Post-Tax) (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.25*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018).
10.26*	Form of Performance Stock Unit Agreement (LTIP) - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018).
10.27*	The Registrant's Management Incentive Plan.
10.28*	The Registrant's Severance Plan for Non-Store Employees amended as of November 28, 2018 (incorporated by reference to Exhibit 10.37 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.29*	The Registrant's Performance-Based Restricted Stock Unit Program, as amended (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.30*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.39 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.31*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.40 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.32*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.41 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.33*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax) (incorporated by reference to Exhibit 10.42 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.34*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Post-Tax) (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013).
10.35*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.5 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.36*	Amended Aetna Inc. 2010 Stock Incentive Plan, as amended May 19, 2017 (incorporated by reference to Exhibit 99.1 to the Registrant's Registration Statement on Form S-8 filed November 30, 2018).
10.37*	Form of Aetna Inc. 2010 Stock Incentive Plan - Market Stock Unit Terms of Award (incorporated by reference to Exhibit 10.45 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).

10.38*	Form of Aetna Inc. 2010 Stock Incentive Plan - Performance Stock Unit Terms of Award (2015) (incorporated by reference to Exhibit 10.46 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).

10.39*	Form of Aetna Inc. 2010 Stock Incentive Plan - Executive Restricted Stock Unit Terms of Award (2015) (incorporated by reference to Exhibit 10.47 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.40*	Form of Aetna Inc. 2010 Stock Incentive Plan - Stock Appreciation Right Terms of Award (2015) (incorporated by reference to Exhibit 10.48 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.41*	Amended and Restated Employment Agreement between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2008).
10.42*	Amendment dated as of December 21, 2012 to the Amended and Restated Employment Agreement between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012).
10.43*	Form of Non-Qualified Stock Option Agreement - Annual Grant between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.37 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.44*	Form of Restricted Stock Unit Agreement - Annual Grant between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.45*	Amendment dated January 22, 2015 to Nonqualified Stock Option Agreements between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed January 23, 2015).
10.46*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.47*	Change in Control Agreement effective as of July 19, 2010 between the Registrant and Eva Boratto (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2019).
10.48*	Restrictive Covenant Agreement dated June 21, 2019 between the Registrant and Eva Boratto.
10.49*	Change in Control Agreement dated December 22, 2008 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012).
10.50*	Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.34 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012).
10.51*	Restricted Stock Unit Agreement - Annual Grant dated April 1, 2016 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.44 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.52*	Restrictive Covenant Agreement dated May 20, 2016 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.45 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.53*	Change in Control Agreement dated as of November 10, 2017 between the Registrant and Derica Rice (incorporated by reference to Exhibit 10.3 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2019).
10.54*	Restrictive Covenant Agreement dated June 19, 2019 between the Registrant and Derica Rice.
10.55*	Change in Control Agreement dated October 1, 2012 between the Registrant and Thomas Moriarty (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2015).
10.56*	Restrictive Covenant Agreement dated July 8, 2019 between the Registrant and Thomas Moriarty.
10.57*	Descriptions of certain arrangements not embodied in formal documents as described under the heading "Non-Employee Director Compensation" are incorporated herein by reference to the Proxy Statement (when filed).
21	**Subsidiaries of the registrant**
21.1	Subsidiaries of CVS Health Corporation.
23	**Consents of experts and counsel**
23.1	Consent of Ernst & Young LLP.

31	**Rule 13a-14(a)/15d-14(a) Certifications**
31.1	Certification by the Chief Executive Officer.

31.2	Certification by the Chief Financial Officer.
32	**Section 1350 Certifications**
32.1	Certification by the Chief Executive Officer.
32.2	Certification by the Chief Financial Officer.
101	**Interactive Data File**
101	The following materials from the CVS Health Corporation Annual Report on Form 10-K for the fiscal year ended December 31, 2019 formatted in Inline XBRL: (i) the Consolidated Statements of Operations, (ii) the Consolidated Statements of Comprehensive Income (Loss), (iii) the Consolidated Balance Sheets, (iv) the Consolidated Statements of Cash Flows, (v) the Consolidated Statements of Shareholders' Equity and (vi) the related Notes to Consolidated Financial Statements. The instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
104	
104	Cover Page Interactive Data File - The cover page from the Company's Annual Report on Form 10-K for the year ended December 31, 2019, formatted in Inline XBRL (included as Exhibit 101).

Item 16. Form 10-K Summary.

None.

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SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

CVS HEALTH CORPORATION

Date: February 18, 2020 By: /s/ EVA C. BORATTO

Eva C. Boratto

Executive Vice President and Chief Financial Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title(s)	Date
/s/ FERNANDO AGUIRRE **Fernando Aguirre**	Director	February 18, 2020
/s/ RICHARD M. BRACKEN **Richard M. Bracken**	Director	February 18, 2020
/s/ C. DAVID BROWN II **C. David Brown II**	Director	February 18, 2020
/s/ EVA C. BORATTO **Eva C. Boratto**	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 18, 2020
/s/ JAMES D. CLARK **James D. Clark**	Senior Vice President - Controller and Chief Accounting Officer (Principal Accounting Officer)	February 18, 2020
/s/ ALECIA A. DECOUDREAUX **Alecia A. DeCoudreaux**	Director	February 18, 2020
/s/ NANCY-ANN M. DEPARLE **Nancy-Ann M. DeParle**	Director	February 18, 2020
/s/ DAVID W. DORMAN **David W. Dorman**	Chair of the Board and Director	February 18, 2020
/s/ ROGER N. FARAH **Roger N. Farah**	Director	February 18, 2020
/s/ ANNE M. FINUCANE **Anne M. Finucane**	Director	February 18, 2020
/s/ EDWARD J. LUDWIG **Edward J. Ludwig**	Director	February 18, 2020
/s/ LARRY J. MERLO **Larry J. Merlo**	President and Chief Executive Officer (Principal Executive Officer) and Director	February 18, 2020
/s/ JEAN-PIERRE MILLON **Jean-Pierre Millon**	Director	February 18, 2020
/s/ MARY L. SCHAPIRO **Mary L. Schapiro**	Director	February 18, 2020
/s/ RICHARD J. SWIFT **Richard J. Swift**	Director	February 18, 2020
/s/ WILLIAM C. WELDON	Director	February 18, 2020

William C. Weldon		
/s/ TONY L. WHITE	Director	February 18, 2020
Tony L. White		

10-K 1 cvs-2018231x10k.htm FORM 10-K

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

☑ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the fiscal year ended December 31, 2018

OR

☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the transition period from _____ to_____
Commission file number 001-01011

cvshealth.jpg

CVS HEALTH CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

(401) 765-1500

(Registrant's telephone number, including area code)

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

Common Stock, par value $0.01 per share	**New York Stock Exchange**
Title of each class	Name of each exchange on which registered

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.	☑ Yes ☐ No
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.	☐ Yes ☑ No
Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.	☑ Yes ☐ No
Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files).	☑ Yes ☐ No
Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.	☐

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

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

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

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

The aggregate market value of the registrant's common stock held by non-affiliates was approximately $65,262,991,789 as of June 30, 2018, based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be the affiliates of the registrant.

As of February 19, 2019, the registrant had 1,297,082,165 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The following materials are incorporated by reference into this Form 10-K:

Portions of the Annual Report to Stockholders for the fiscal year ended December 31, 2018 (the "Annual Report") are incorporated by reference in response to Items 1, 1A, 2 and 3 of Part I and Items 5, 6, 7, 7A, 8 and 9A of Part II, in each case to the extent described therein.

Information contained in the definitive proxy statement for CVS Health Corporation's 2019 Annual Meeting of Stockholders, to be filed on or about April 5, 2019 (the "Proxy Statement"), is incorporated by reference in response to Items 10 through 14 of Part III to the extent described therein.

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PART I

Item 1. Business

Overview

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is the nation's premier health innovation company helping people on their path to better health. Whether in one of its pharmacies or through its health services and plans, CVS Health is pioneering a bold new approach to total health by making quality care more affordable, accessible, simple and seamless. CVS Health is community-based and locally focused, engaging consumers with the care they need when and where they need it. The Company has more than 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 92 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year, expanding specialty pharmacy services, and a leading stand-alone Medicare Part D prescription drug plan. CVS Health also serves an estimated 38 million people through traditional, voluntary and consumer-directed health insurance products and related services, including rapidly expanding Medicare Advantage offerings. The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

On November 28, 2018 (the "Aetna Acquisition Date"), the Company acquired Aetna Inc. ("Aetna") for a combination of cash and CVS Health stock (the "Aetna Acquisition"). The Company acquired Aetna to help improve the consumer health care experience by combining Aetna's health care benefits products and services with CVS Health's more than 9,900 retail locations, approximately 1,100 walk-in medical clinics and integrated pharmacy capabilities with the goal of becoming the new, trusted front door to health care. Under the terms of the merger agreement, Aetna shareholders received $145.00 in cash and 0.8378 CVS Health shares for each Aetna share. The transaction valued Aetna at approximately $212 per share or approximately $70 billion. Including the assumption of Aetna's debt, the total value of the transaction was approximately $78 billion. The Company financed the cash portion of the purchase price through a combination of cash on hand and by issuing approximately $45.0 billion of new debt, including senior notes and term loans. For additional information, see Note 2 ''Acquisition of Aetna'' contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

On October 10, 2018, the Company and Aetna entered into a consent decree with the United States Department of Justice (the "DOJ") that allowed the Company's proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone Medicare Part D prescription drug plans. As part of the agreement reached with the DOJ, Aetna entered into a purchase agreement with a subsidiary of WellCare Health Plans, Inc. ("WellCare") for the divestiture of Aetna's standalone Medicare Part D prescription drug plans effective December 31, 2018. On November 30, 2018, Aetna completed the sale of its standalone Medicare Part D prescription drug plans. Aetna's standalone Medicare Part D prescription drug plans had an aggregate of approximately 2.3 million members as of December 31, 2018. Aetna will provide administrative services to, and will retain the financial results of, the divested plans through 2019.

As a result of the Aetna Acquisition, the Company added the Health Care Benefits segment, which is the equivalent of the former Aetna Health Care segment. Certain aspects of Aetna's operations, including products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, are included in the Company's Corporate/Other segment. The Company now has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other.

Business Strategy

The combined company expects to transform the consumer health care experience and build healthier communities through a new innovative health care model that is local, easier to use, less expensive and puts consumers at the center of their care. The Company believes that improving the consumer's health care experience will improve consumer engagement with their health which will lead to improved health outcomes and lower total health care costs. The Company believes there are three imperatives to accomplishing this transformation: be local, make it simple and improve health. These imperatives also guide the Company's five key strategies for delivering medical cost savings for its customers: improve common chronic disease management, reduce unnecessary hospital

readmissions, improve the efficiency of the sites at which medical members receive care, optimize primary care delivery and improve the Company's complex chronic disease management capabilities.

Pharmacy Services Segment

The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services, mail order pharmacy, specialty pharmacy and infusion services, Medicare Part D services, clinical services, disease management services and medical spend management. The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D prescription drug plans ("PDPs"), Medicaid managed care ("Managed Medicaid") plans, plans offered on public health insurance exchanges ("Public Exchanges") and private health insurance exchanges ("Private Exchanges" and together with Public Exchanges, "Insurance Exchanges"), other sponsors of health benefit plans and individuals throughout the United States. In addition, the Company is a national provider of drug benefits to eligible beneficiaries under the Medicare Part D prescription drug program. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services. During the year ended December 31, 2018, the Company's PBM filled or managed approximately 1.9 billion prescriptions on a 30-day equivalent basis.

PBM Services

The Company dispenses prescription drugs directly through its mail order dispensing and specialty mail order pharmacies and through pharmacies in its retail network. All prescriptions processed by the Company are analyzed, processed and documented by the Company's proprietary prescription management systems. These systems provide essential features and functionality to allow a plan member to utilize their prescription drug benefits. These systems also streamline the process by which prescriptions are processed by staff and network pharmacists by enhancing review of various items through automation, including plan eligibility, early refills, duplicate dispensing, appropriateness of dosage, drug interactions or allergies, over-utilization and potential fraud.

Plan Design Offerings and Administration
The Company administers pharmacy benefit plans for clients who contract with it to facilitate prescription drug coverage and claims processing for their eligible plan members. The Company assists its PBM clients in designing pharmacy benefit plans that help improve health outcomes while minimizing the costs to the client. The Company also assists PBM clients in monitoring the effectiveness of their plans through frequent, informal communications, the use of proprietary software, as well as through formal annual, quarterly and sometimes monthly performance reviews.

The Company makes recommendations to help PBM clients design benefit plans that promote the use of lower cost, clinically appropriate drugs and helps its PBM clients control costs by recommending plan designs that encourage the use of generic equivalents of brand name drugs when such equivalents are available. Clients also have the option, through plan design, to further lower their pharmacy benefit plan costs by setting different member payment levels for different products on their drug lists or "formularies," which helps guide members to choose lower cost alternatives through appropriate financial incentives.

Formulary Management
The Company utilizes an independent panel of doctors, pharmacists and other medical experts, referred to as the CVS Caremark National Pharmacy and Therapeutics Committee, to review and approve the selection of drugs that meet the Company's standards of safety and efficacy for inclusion on one of the Company's template formularies. The Company's formularies provide recommended products in numerous drug classes to help ensure member access to clinically appropriate drugs with alternatives within a class under the client's pharmacy benefit plan, while helping to drive the lowest net cost for clients that select one of the Company's formularies. To help improve clinical outcomes for members and clients, the Company conducts ongoing, independent reviews of all drugs, including, but not limited to, those appearing on the formularies and generic equivalent products. Many of the Company's clients choose to adopt a template formulary offering as part of their plan design. Beginning in 2018, clients had new capabilities to offer real time benefits information for a member's specific plan design, provided digitally at the point of prescribing, at the pharmacy and directly to members.

Retail Pharmacy Network Management Services
The Company maintains a national network of more than 68,000 retail pharmacies, consisting of approximately 41,000 chain pharmacies (which includes CVS Pharmacy locations) and 27,000 independent pharmacies, in the United States, including Puerto Rico, the District of Columbia, Guam and the United States Virgin Islands. When a customer fills a prescription in a retail pharmacy, the pharmacy sends prescription data electronically to the Company

from the point-of-sale. This data interfaces with the Company's proprietary prescription management systems, which verify relevant plan member data and eligibility, while also performing a drug utilization review to help evaluate clinical appropriateness and safety and confirming that the pharmacy will receive payment for the prescription. The Company is also able to build client-specific pharmacy networks and

managed pharmacy network solutions to further drive savings for clients. These include a performance-based pharmacy network with approximately 30,000 stores that is anchored by CVS Pharmacy and Walgreens, along with up to 10,000 independent pharmacies across the United States. The performance-based network is designed to deliver unit cost savings and to improve clinical outcomes in order to help to lower overall health care costs for participating payors and their members.

Mail Order Pharmacy Services
The Pharmacy Services segment operates mail order dispensing pharmacies in the United States. Plan members or their prescribers submit prescriptions or refill requests, primarily for maintenance medications, to these pharmacies via mail, telephone, fax, e-prescribing or the Internet, and staff pharmacists review these prescriptions and refill requests with the assistance of the Company's prescription management systems. This review may involve communications with the prescriber and, with the prescriber's approval when required, can result in generic substitution, therapeutic interchange or other actions designed to help reduce cost and/or improve quality of treatment. The Company's mail order dispensing pharmacies have been awarded Mail Order Pharmacy accreditation from Utilization Review Accreditation Commission ("URAC"), a health care accrediting organization that establishes quality standards for the health care industry.

Specialty Pharmacy and Infusion Services
The Pharmacy Services segment operates specialty mail order pharmacies, retail specialty pharmacy stores and branches for infusion and enteral nutrition services in the United States. These specialty mail order pharmacies are used for delivery of advanced medications to individuals with chronic or genetic diseases and disorders. The Company's specialty mail order pharmacies also have been awarded Specialty Pharmacy accreditation from URAC. Substantially all of the Company's mail service specialty mail order pharmacies also have been accredited by the Joint Commission, which is an independent, not-for-profit organization that accredits and certifies health care programs and organizations in the United States.

Medicare Part D Services
The Company participates in the administration of the Medicare Part D prescription drug program through the provision of PBM services to those health plan clients and other clients that have qualified as a PDP or as a Medicare Advantage prescription drug plan and by offering Medicare Part D pharmacy benefits through its SilverScript subsidiary that is a PDP that has contracted with the United States Centers for Medicare & Medicaid Services ("CMS"). The Company also assists employer, union and other health plan clients that qualify for the retiree drug subsidy made available under Medicare Part D by collecting and submitting eligibility and/or drug cost data to CMS in order for such clients to obtain the subsidy and offers Medicare Part D pharmacy benefits to such clients' retirees through Employer Group Waiver Plans ("EGWPs") sponsored by SilverScript.

Clinical Services
The Company offers multiple clinical programs and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner. These programs are primarily designed to promote better health outcomes, and to help target inappropriate medication utilization and non-adherence to medication, each of which may result in adverse medical events that negatively affect member health and client pharmacy and medical spend. These programs include utilization management ("UM"), medication management, quality assurance, adherence and counseling programs to complement the client's plan design and clinical strategies. To help address the opioid epidemic, the Company introduced an industry-leading UM approach that limits to seven days the supply of opioids dispensed for certain acute prescriptions for patients who are new to therapy; limits the daily dosage of opioids dispensed based on the strength of the opioid; and requires the use of immediate-release formulations of opioids before extended-release opioids are dispensed. The Company's Pharmacy Advisor program facilitates pharmacist counseling, both face-to-face and over the telephone, to help participating plan members with certain chronic diseases, such as diabetes and cardiovascular conditions, to identify gaps in care, adhere to their prescribed medications and manage their health conditions. The Company also has digital connectivity that helps to lower drug costs for patients by providing expanded visibility to lower cost alternatives through enhanced analytics and data sharing.

Disease Management Programs
The Company's clinical programs and services utilize advanced protocols and offer clients convenience in working with health care providers ("providers") and other third parties. The Company's integrated disease management programs cover diseases such as rheumatoid arthritis, Parkinson's disease, seizure disorders and multiple sclerosis. The majority of these integrated programs are accredited by the National Committee for Quality Assurance

("NCQA"), a private, not-for-profit organization that evaluates, accredits and certifies a wide range of health care organizations.

Medical Benefit Management
The Company's NovoLogix® online preauthorization tool helps identify and capture cost savings opportunities for specialty drugs billed under the medical benefit by identifying outliers to appropriate dosages and costs, and helps to ensure clinically appropriate use of specialty drugs.

Pharmacy Services Information Systems

The majority of the Pharmacy Services segment's clients have migrated to a single claim adjudication platform. This platform incorporates architecture that centralizes the data generated from filling mail order prescriptions, adjudicating retail pharmacy claims and delivering other solutions to PBM clients. The Health Engagement Engine® technology and proprietary clinical algorithms help connect the various parts of the enterprise and serve an essential role in cost management and health improvement. This capability transforms pharmacy data into actionable interventions at key points of care such as mail and specialty pharmacists to help provide quality care.

Pharmacy Services Clients

The Company's Pharmacy Services clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D plans, Managed Medicaid plans and plans offered on public and private health insurance exchanges, other sponsors of health benefit plans and individuals located throughout the United States. Pharmaceuticals are provided to eligible members in benefit plans maintained by clients and utilize the Company's information systems, among other things, to help perform safety checks, drug interaction screening and identify opportunities for generic substitution. Substantially all of the Pharmacy Services segment's revenue is generated from dispensing and managing prescription drugs to eligible members in benefit plans maintained by clients. In 2018, 2017 and 2016, revenues from Aetna accounted for approximately 9.8%, 12.3% and 11.7%, respectively, of the Company's consolidated total revenues. On the Aetna Acquisition Date, Aetna became a wholly-owned subsidiary of CVS Health. Subsequent to the Aetna Acquisition Date, revenues from Aetna will continue to be reported in the Pharmacy Services segment; however, these revenues are eliminated in the consolidated financial statements.

Pharmacy Services Seasonality

The majority of Pharmacy Services segment revenues are not seasonal in nature. However, quarterly earnings and operating cash flows are impacted by the Medicare Part D benefit design and changes in the composition of PDP membership. The Medicare Part D standard benefit design results in coverage that varies with a member's cumulative annual out-of-pocket costs. The benefit design generally results in employers or other entities that sponsor the Company's products ("plan sponsors") sharing a greater portion of the responsibility for total prescription drug costs in the early part of the year. As a result, the PDP pay percentage or benefit ratio generally decreases and operating income generally increases as the year progresses.

Pharmacy Services Competition

The Company believes the primary competitive factors in the pharmacy services industry include: (i) the ability to negotiate favorable discounts from drug manufacturers as well as to negotiate favorable discounts from, and access to, retail pharmacy networks; (ii) the ability to identify and apply effective cost management programs utilizing clinical strategies, including the development and utilization of preferred formularies; (iii) the ability to market PBM products and services; (iv) the commitment to provide flexible, clinically-oriented services to clients and be responsive to clients' needs; (v) the quality, scope and costs of products and services offered to clients and their members; and (vi) operational excellence in delivering services. The Pharmacy Services segment has a significant number of competitors (e.g., the Express Scripts business of Cigna Corporation, OptumRx, Prime Therapeutics, MedImpact and Humana) offering PBM services, including large, national PBM companies, PBMs owned by large national health plans and smaller standalone PBMs. References to competitors and other companies throughout this Annual Report on Form 10-K, including the information incorporated by reference herein, are for illustrative or comparison purposes only and do not indicate that these companies are the Company's or any segment's only competitors or closest competitors.

Retail/LTC Segment

The Retail/LTC segment sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products, cosmetics and personal care products, provides health care services through its MinuteClinic® walk-in medical clinics and conducts long-term care ("LTC") pharmacy operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. Prior to January 2, 2018, the Retail/LTC segment also provided commercialization services under the name RxCrossroads®. The Company divested its RxCrossroads subsidiary on January 2, 2018. As of December 31, 2018, the Retail/LTC segment operated more than 9,900 retail locations, over 1,100 MinuteClinic® locations as

well as online retail pharmacy websites, LTC pharmacies and onsite pharmacies. During the year ended December 31, 2018, the Retail/LTC segment filled approximately 1.3 billion prescriptions

on a 30-day equivalent basis. In December 2018, the Company held approximately 26% of the United States retail pharmacy market.

Retail/LTC Products and Services

A typical retail store sells prescription drugs and a wide assortment of high-quality, nationally advertised brand name and proprietary brand merchandise. Front store categories include over-the-counter drugs, beauty products, cosmetics and personal care products. LTC operations include distribution of prescription drugs and related consulting and ancillary services. The Company purchases merchandise from numerous manufacturers and distributors. The Company believes that competitive sources are readily available for substantially all of the products carried in its retail stores and the loss of any one supplier would not likely have a material effect on the Retail/LTC segment. The Company's MinuteClinics offer a variety of health care services.

Retail/LTC revenues by major product group are as follows:

	Percentage of Revenues		
	2018	**2017**	**2016**
Pharmacy [1]	76.4%	75.0%	75.0%
Front store and other [2]	23.6%	25.0%	25.0%
	100.0%	100.0%	100.0%

(1) Pharmacy includes LTC sales and sales in pharmacies within Target Corporation stores.

(2) "Other" represents less than 5% of the "Front store and other" revenue category.

Pharmacy
Pharmacy revenues represented approximately three-fourths of Retail/LTC segment revenues in each of 2018, 2017 and 2016. The Company believes that retail pharmacy operations will continue to represent a critical part of the Company's business due to industry demographics, e.g., an aging American population consuming a greater number of prescription drugs, prescription drugs being used more often as the first line of defense for managing illness, the introduction of new pharmaceutical products, and Medicare Part D growth. The Company believes the retail pharmacy business benefits from investment in both people and technology, as well as innovative collaborations with health plans, PBMs and providers. Given the nature of prescriptions, consumers want their prescriptions filled accurately by professional pharmacists using the latest tools and technology, and ready when promised. Consumers also need medication management programs and better information to help them get the most out of their health care dollars. To assist consumers with these needs, the Company has introduced integrated pharmacy health care services that provide an earlier, easier and more effective approach to engaging consumers in behaviors that can help lower costs, improve health and save lives.

Front Store
Front store revenues reflect the Company's strategy of innovating with new and unique products and services, using innovative personalized marketing and adjusting the mix of merchandise to match customers' needs and preferences. A key component of the front store strategy is the ExtraCare® card program, which is one of the largest and most successful retail loyalty programs in the United States. The ExtraCare program allows the Company to balance marketing efforts so it can reward its best customers by providing them with automatic sale prices, customized coupons, ExtraBucks® rewards and other benefits. The Company continues to launch and enhance new and exclusive brands to create unmatched offerings in beauty products and deliver other unique product offerings, including a full range of high-quality CVS Health and other proprietary brand products that are only available through CVS stores. The Company currently carries approximately 7,000 CVS Health and proprietary brand products, which accounted for approximately 23% of front store revenues during 2018.

MinuteClinic
As of December 31, 2018, the Company operated approximately 1,100 MinuteClinic® locations in the United States. The clinics are staffed by nurse practitioners and physician assistants who utilize nationally established guidelines to deliver a variety of health care services. Payors value these clinics because they provide convenient, high-quality, cost-effective care, in many cases offering an attractive alternative to more expensive sites of care. As a result, visits paid for by employers, health insurers or other third parties accounted for approximately 91% of MinuteClinic's total

revenues in 2018. MinuteClinic is collaborating with the Pharmacy Services and Health Care Benefits segments to help meet the needs of CVS Caremark's client plan members and the Company's health plan members by offering programs that can improve member health and lower costs.

MinuteClinic is now affiliated with more than 75 major health systems and continues to build a platform that supports primary care.

Long-term Care Pharmacy Operations
The Retail/LTC segment provides LTC pharmacy services through the Omnicare business. Omnicare's customers consist of skilled nursing facilities, assisted living facilities, independent living communities, hospitals, correctional facilities, and other health care service providers. The Company provides pharmacy consulting, including monthly patient drug therapy evaluations, to assist in compliance with state and federal regulations and provide proprietary clinical and health management programs. It also provides pharmaceutical case management services for retirees, employees and dependents who have drug benefits under corporate-sponsored health care programs.

Onsite Pharmacies
The Company also operates a limited number of pharmacies located at client sites, which provide certain health plan members and customers with a convenient alternative for filling their prescriptions.

Retail Store Development

The addition of new retail locations has played, and will continue to play, a key role in the Company's continued growth and success. The Company's store development program focuses on three areas: entering new markets, adding stores within existing markets and relocating stores to more convenient sites. During 2018, the Company opened 145 new retail locations, relocated approximately 35 stores and closed approximately 30 locations. During the last five years, the Company opened approximately
900 new and relocated locations, and acquired approximately 1,825 locations, including the pharmacies acquired from Target Corporation ("Target") in 2015. The Company believes that continuing to grow its store base appropriately and locate retail stores in more accessible markets are essential components of competing effectively in the current health care environment. As a result, the Company believes that its store development program is an integral part of its ability to meet the needs of customers and maintain its leadership position in the retail pharmacy market given the changing health care landscape.

Retail/LTC Information Systems

The Company has continued to invest in information systems to enable it to deliver exceptional customer service, enhance safety and quality, and expand patient care services while lowering operating costs. The proprietary WeCARE Workflow supports pharmacy teams by prioritizing work to meet customer expectations, facilitating prescriber outreach, and seamlessly integrating clinical programs. This solution delivers improved efficiency and enhances the customer experience, as well as providing a framework to accommodate the evolution of pharmacy practice and the expansion of clinical programs. The Health Engagement Engine technology and proprietary clinical algorithms enable the Company to help identify opportunities for pharmacists to deliver face-to-face counseling regarding patient health and safety matters, including adherence issues, gaps in care and management of certain chronic health conditions. The Company's digital strategy is to empower the consumer to navigate their pharmacy experience and manage their condition through integrated online and mobile solutions that offer utility and convenience. The Company's LTC digital technology suite, Omniview®, improves the efficiency of customers' operations with tools that include executive dashboards, pre-admission pricing, electronic ordering of prescription refills, proof-of-delivery tracking, access to patient profiles, receipt and management of facility bills, and real-time validation of Medicare Part D coverage, among other capabilities.

Retail/LTC Customers

The success of the Retail/LTC segment's businesses is dependent upon the Company's ability to establish and maintain contractual relationships with pharmacy benefit managers and other payors on acceptable terms. Pharmacy benefit managers, managed care organizations, government funded health care programs, commercial employers and other third party payors accounted for 99.5% of the Retail/LTC segment's pharmacy revenues. No single Retail/LTC payor accounted for 10% or more of the Company's consolidated total revenues in 2018, 2017 or 2016.

Retail/LTC Seasonality

The majority of Retail/LTC segment revenues, particularly pharmacy revenues, generally are not seasonal in nature. However, front store revenues tend to be higher during the December holiday season. In addition, both pharmacy and front store revenues are affected by the timing and severity of the cough, cold and flu season. Uncharacteristic or

extreme weather conditions also can adversely affect consumer shopping patterns and Retail/LTC revenues, expenses and results of operations.

Retail/LTC Competition

The retail drugstore business is highly competitive. The Company believes that it competes principally on the basis of: (i) store location and convenience, (ii) customer service and satisfaction, (iii) product selection and variety, and (iv) price. In the markets it serves, the Company competes with other drugstore chains (e.g., Walgreens and Rite Aid), supermarkets, discount retailers (e.g., Wal-Mart), independent pharmacies, restrictive pharmacy networks, membership clubs, Internet companies, and retail health clinics (including urgent care centers), as well as mail order dispersing pharmacies.

LTC pharmacy services are highly regional or local in nature, and within a given geographic area of operation, highly competitive. The Company's largest LTC pharmacy competitor nationally is PharMerica. The Company also competes with numerous local and regional institutional pharmacies, pharmacies owned by long-term care facilities and local retail pharmacies. Some states have enacted "freedom of choice" or "any willing provider" requirements as part of their state Medicaid programs or in separate legislation, which may increase the competition that the Company faces in providing services to long-term care facility residents in these states.

References to competitors and other companies throughout this Annual Report on Form 10-K, including the information incorporated by reference herein, are for illustrative or comparison purposes only and do not indicate that these companies are the Company's or any segment's only competitors or closest competitors.

Health Care Benefits Segment

The Health Care Benefits segment is one of the nation's leading diversified health care benefits providers, serving an estimated 38 million people as of December 31, 2018. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make better informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services, workers' compensation administrative services and health information technology ("HIT") products and services. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers, governmental units, government-sponsored plans, labor groups and expatriates.

Health Care Benefits Products and Services

The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk of medical and dental care costs) as "ASC." Health Care Benefits products and services consist of the following:

- *Commercial Medical*: The Health Care Benefits segment offers point-of-service ("POS"), preferred provider organization ("PPO"), health maintenance organization ("HMO") and indemnity benefit ("Indemnity") plans. Commercial medical products also include health savings accounts ("HSAs") and consumer-directed health plans that combine traditional POS or PPO and/or dental coverage, subject to a deductible, with an accumulating benefit account (which may be funded by the plan sponsor and/or the member in the case of HSAs). Principal products and services are targeted specifically to large multi-site national, mid-sized and small employers, individual insureds and expatriates. The Company offers medical stop loss insurance coverage for certain employers who elect to self-insure their health benefits. Under this product, the Company assumes risk for costs associated with large individual claims and/or aggregate loss experience within an employer's plan above a pre-set annual threshold.

- *Government Medical*: In select geographies, the Health Care Benefits segment offers Medicare Advantage plans, Medicare Supplement plans and prescription drug coverage for Medicare beneficiaries; participates in Medicaid and subsidized Children's Health Insurance Programs ("CHIP"); and participates in demonstration projects for members who are eligible for both Medicare and Medicaid ("Duals"). These Government Medical products are further described below:

    - *Medicare Advantage and PDP:* Through annual contracts with CMS, the Company offers HMO and PPO products for eligible individuals in certain geographic areas through the Medicare Advantage

program. Members typically receive enhanced benefits over traditional fee-for-service Medicare coverage (“Original Medicare”), including reduced cost-sharing for preventive care, vision and other services. The Company offered network-based HMO and/or PPO plans in 1,317 counties in 40 states and Washington, D.C. in 2018. The Company has expanded to 1,416 counties in 45 states and Washington, D.C. for 2019. The Company is a national provider of drug benefits under the Medicare Part D prescription drug program to both individuals and EGWPs. All Medicare eligible individuals are eligible to participate in this voluntary prescription drug plan. Members typically receive

coverage for certain prescription drugs, usually subject to a deductible, co-insurance and/or co-payment. On November 30, 2018, Aetna completed the sale of all of its standalone Medicare Part D prescription drug plans to WellCare effective on December 31, 2018. Aetna will provide administrative services to, and retain the financial results of, the divested plans through 2019. For certain qualifying employer groups, the Company offers Medicare PPO products nationally. When combined with the Company's PDP product, these national PPO plans form an integrated national Insured Medicare product for employers that provides medical and pharmacy benefits.

- *Medicare Supplement:* For certain Medicare eligible members, the Company offers supplemental coverage for certain health care costs not covered by Original Medicare. The products included in the Medicare Supplement portfolio help to cover some of the gaps in Original Medicare, and include coverage for Medicare deductibles and coinsurance amounts. The Company offered a wide selection of Medicare Supplement products in 49 states and Washington, D.C. in 2018.

- *Medicaid and CHIP:* The Company offers health care management services to individuals eligible for Medicaid and CHIP under multi-year contracts with government agencies in various states that are subject to annual appropriations. CHIP are state-subsidized insurance programs that provide benefits for families with uninsured children. The Company offered these services on an Insured or ASC basis in 16 states in 2018.

- *Duals:* The Company provides health coverage to beneficiaries who are dually eligible for both Medicare and Medicaid coverage. These members must meet certain income and resource requirements in order to qualify for this coverage. The Company coordinates 100% of the care for these members and may provide them with additional services in order to manage their health care costs. During 2018, the Company offered services on an Insured basis to Duals in four states under demonstration projects.

- *Pharmacy*: The Company offers PBM services and specialty and home delivery pharmacy services. The Company also performs various PBM services for Aetna pharmacy customers consisting of: product development, Commercial formulary management, pharmacy rebate contracting and administration, sales and account management and precertification programs. The Pharmacy Services segment performs the administration of selected functions for retail pharmacy network contracting and claims administration; home delivery and specialty pharmacy order fulfillment and inventory purchasing and management; and certain administrative services. Other suppliers also provide certain PBM services.

- *Specialty*: The Health Care Benefits segment has a portfolio of additional health products and services that complement its medical products such as dental plans, behavioral health and employee assistance products, provider network access and vision products and workers' compensation administrative services.

- *Consumer Health Products and Services*: The Company has a portfolio of products and services aimed at creating a holistic and integrated approach to individual health and wellness. These products and services complement the Commercial Medical and Government Medical products and enable enhanced delivery to and experience for customers.

Health Care Benefits Provider Networks

The Company contracts with physicians, hospitals and other providers for services they provide to members. The Company uses a variety of techniques designed to help encourage appropriate utilization of medical services ("utilization") and maintain affordability of quality coverage. In addition to contracts with providers for negotiated rates of reimbursement, these techniques include creating risk sharing arrangements that align economic incentives with providers, the development and implementation of guidelines for the appropriate utilization of medical services and the provision of data to providers to enable them to improve health care quality. At December 31, 2018, the Company's underlying nationwide provider network had approximately 1.3 million participating providers, including over 697 thousand primary care and specialist physicians and approximately 5,700 hospitals. Other providers in the Company's provider networks also include laboratory, imaging, urgent care and other freestanding health facilities.

Health Care Benefits Quality Assessment

CMS uses a 5-star rating system to monitor Medicare health care and drug plans and ensure that they meet CMS's quality standards. CMS uses this rating system to provide Medicare beneficiaries with a tool that they can use to compare the overall quality of care and level of customer service of companies that provide Medicare health care and drug plans. The rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management and overall customer satisfaction. See "Health Care Benefits Pricing" below in this Item 1 for further discussion of star ratings. The Company seeks Health Plan accreditation for Aetna HMO plans from the NCQA. Health care plans seeking accreditation must pass a rigorous, comprehensive review and must annually report on their performance.

Aetna Life Insurance Company ("ALIC"), a wholly-owned subsidiary of the Company, has received nationwide NCQA PPO Health Plan accreditation. As of December 31, 2018, all of the Company's Commercial HMO and all of ALIC's PPO members who were eligible participated in HMOs or PPOs that are accredited by the NCQA.

The Company's provider selection and credentialing/re-credentialing policies and procedures are consistent with NCQA and URAC, as well as state and federal, requirements. In addition, the Company is certified under the NCQA Credentials Verification Organization ("CVO") certification program for all certification options and has URAC CVO accreditation.

Quality assessment programs for contracted providers who participate in the Company's networks begin with the initial review of health care practitioners. Practitioners' licenses and education are verified, and their work history is collected by the Company or in some cases by the practitioner's affiliated group or organization. The Company generally requires participating hospitals to be certified by CMS or accredited by the Joint Commission, the American Osteopathic Association, or Det Norske Veritas Healthcare.

The Company also offers quality and outcome measurement programs, quality improvement programs, and health care data analysis systems to providers and purchasers of health care services.

Health Care Benefits Information Systems

The Health Care Benefits segment currently operates and supports an end to end suite of information technology platforms to support member engagement, enrollment, health benefit administration, care management, service operations, financial reporting and analytics. The multiple platforms are supported by an integration layer to facilitate the transfer of real-time data. There is continued focus and investment in digital products to offer innovative solutions and a seamless experience to the Company's members through mobile and web channels. Capabilities available to members include digital wallet, provider search, cost transparency and behavioral monitoring. The Health Care Benefits segment care management solution supports the Company's clinicians with data and recommendations. The Company continues to scale its clinical platform and its local personalized care model. The Company aims to build an integrated 360 degree view of the member to ensure that it can guide them through their healthcare journey and provide them a high level of service. Through its analytics platform the Company is beginning to harness the power of data to help drive healthier outcomes and proactive care and enable consumers to take the next best action for their health.

Health Care Benefits Customers

Medical membership is dispersed throughout the United States, and the Company also serves medical members in certain countries outside the United States. See Note 17 ''Segment Reporting'' contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein, for additional information on foreign customers. The Company offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, many of which are available nationwide. Depending on the product, the Company markets to a range of customers including employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans, labor groups and expatriates.

The following table presents total medical membership by United States and other geographic region and funding arrangement at December 31, 2018:

In thousands	**Insured**	**ASC**	**Total**
Northeast	1,961	3,232	5,193
Southeast	1,752	2,886	4,638
Mid-America	1,632	2,530	4,162
West	1,618	4,510	6,128
Other	587	1,393	1,980
Total medical membership	7,550	14,551	22,101

For additional information on medical membership, see the caption “Management’s Discussion and Analysis of Financial Condition and Results of Operations — Health Care Benefits Segment” in the Annual Report, which section is incorporated by reference herein.

The Company markets both Commercial Insured and ASC products and services primarily to employers that sponsor the Company's products for the benefit of their employees and their employees' dependents. Frequently, larger employers offer employees a choice among coverage options, from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to the Company and, through payroll deductions, obtain reimbursement from employees for a percentage of the premiums that is determined by each employer. Some Health Care Benefits products are sold directly to employees of employer groups on a fully employee-funded basis. In some cases, the Company bills the covered individual directly.

The Company offers Insured Medicare coverage on an individual basis as well as through employer groups to their retirees. Medicaid and CHIP members are enrolled on an individual basis. The Company also offers Insured health care coverage to members who are dually-eligible for both Medicare and Medicaid.

Health Care Benefits products are sold through the Company's sales personnel; through independent brokers, agents and consultants who assist in the production and servicing of business; and Private Exchanges. For large plan sponsors, independent consultants and brokers are frequently involved in employer health plan selection decisions and sales. In some instances, the Company may pay commissions, fees and other amounts to brokers, agents, consultants and sales representatives who place business with the Company. In certain cases, the customer pays the broker for services rendered, and the Company may facilitate that arrangement by collecting the funds from the customer and transmitting them to the broker. The Company supports marketing and sales efforts with an advertising program that may include television, radio, billboards, print media and social media, supplemented by market research and direct marketing efforts.

The United States federal government is a significant customer of the Health Care Benefits segment through contracts with CMS for coverage of Medicare-eligible individuals, federal employee-related benefit programs and Medicaid products and services. Other than the contracts with CMS, the Health Care Benefits segment is not dependent upon a single customer or a few customers the loss of which would have a significant effect on the earnings of the segment. The loss of business from any one, or a few, independent brokers or agents would not have a material adverse effect on the earnings of the Health Care Benefits segment. For additional information, see Note 17 ''Segment Reporting'' contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

Health Care Benefits Pricing

For Commercial Insured plans, contracts containing the pricing and other terms of the relationship are generally established in advance of the policy period and typically have a duration of one year. Fees under ASC plans are generally fixed for a period of one year.

Generally, a fixed premium rate is determined at the beginning of the policy period for Commercial Insured plans. The Company typically cannot recover unanticipated increases in health care and other benefit costs in the current policy period; however, it may consider prior experience for a product in the aggregate or for a specific customer, among other factors, in determining premium rates for future policy periods. Where required by state laws, premium rates are filed and approved by state regulators prior to contract inception. Future results of operations could be adversely affected if the premium rates requested are not approved or are adjusted downward or their approval is delayed by state or federal regulators.

The Company has Medicare Advantage and PDP contracts with CMS to provide HMO, PPO and prescription drug coverage to Medicare beneficiaries in certain geographic areas. Under these annual contracts, CMS pays the Company a fixed capitation payment and/or a portion of the premium, both of which are based on membership and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed capitation payment or premium. PDP contracts also provide a risk-sharing arrangement with CMS to limit the Company's exposure to unfavorable expenses or benefit from favorable expenses. Amounts payable to the Company under the Medicare arrangements are subject to annual revision by CMS, and the Company elects to participate in each Medicare service area or region on an annual basis. Premiums paid to the Company for Medicare products are subject to federal government reviews and audits, which can result, and have resulted, in retroactive and prospective premium adjustments and refunds to the government and/or members. In addition to payments received from CMS, some of Medicare Advantage products and all PDP products require a supplemental premium to be paid by the member or sponsoring employer. In some cases these supplemental premiums are adjusted based on the member's income and asset levels. Compared to

Commercial Medical products, Medicare contracts generate higher per member per month revenues and health care and other benefit costs.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, the “ACA”) ties a portion of each Medicare Advantage plan’s reimbursement to the plan’s “star ratings.” Since 2015, plans must have a star rating of four or higher (out of five) to qualify for a quality bonus in their basic premium rates. CMS released 2019

star ratings in October 2018. The 2019 star ratings will be used to determine which Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2020. Based on membership at December 31, 2018, 79% of the Company's Medicare Advantage members were in plans with 2019 star ratings of at least 4.0 stars.

Rates for Medicare Supplement products are regulated at the state level and vary by state and plan.

Under Insured Medicaid contracts, state government agencies pay the Company fixed monthly rates per member that vary by state, line of business and demographics; and the Company arranges, pays for and manages the health care services provided to Medicaid beneficiaries. These rates are subject to change by each state, and, in some instances, provide for adjustment for health risk factors. CMS requires these rates to be actuarially sound. The Company also receives fees from customers where it provides services under ASC Medicaid contracts. ASC Medicaid contracts generally are for periods of more than one year, and certain of them contain performance incentives and limited financial risk sharing with respect to certain medical, financial and operational metrics. Under these arrangements, performance is evaluated annually, with associated financial incentive opportunities, and financial risk share obligations are typically limited to a percentage of the fees otherwise payable to the Company. Payments to the Company under Medicaid contracts are subject to the annual appropriation process in the applicable state.

Under Duals contracts, the rate setting process is generally established by CMS in partnership with the state government agency participating in the demonstration project. Both CMS and the state government agency may seek premium and other refunds under certain circumstances, including if the Company fails to comply with CMS regulations or other contractual requirements.

The Company offers HMO and consumer-directed medical and dental plans to federal employees under the Federal Employees Health Benefits ("FEHB") Program and the Federal Employees Dental and Vision Insurance Program. Premium rates and fees for those plans are subject to federal government review and audit, which can result, and have resulted, in retroactive and prospective premium and fee adjustments and refunds to the government and/or members.

Beginning in 2014, the ACA imposed significant new industry-wide fees, assessments and taxes, including an annual levy called the Health Insurer Fee (the "HIF"). In December 2015, the Consolidated Appropriation Act was enacted, which included a one year suspension of the HIF for 2017. In January 2018, the HIF was suspended for 2019. For additional information on the ACA fees, assessments and taxes, see Note 1 ''Significant Accounting Policies'' contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein. The Company's goal is to collect in premiums and fees where possible, or solve for all of these ACA-related fees, assessments and taxes.

Health Care Benefits Seasonality

The majority of Health Care Benefits segment revenues are not seasonal in nature. However, the Health Care Benefits segment's quarterly operating income progression is impacted by (i) the seasonality of benefit costs which generally increase during the year as Insured members progress through their annual deductibles and out-of-pocket expense limits and (ii) the seasonality of operating expenses which are generally the highest during the fourth quarter due to increased marketing spending associated with Medicare annual enrollment. As a result, the Health Care Benefits segment's operating income generally is the highest in the first quarter of the year and lowest in the fourth quarter of the year.

Health Care Benefits Competition

The health care benefits industry is highly competitive, primarily due to a large number of for-profit and not-for-profit competitors, competitors' marketing and pricing and a proliferation of competing products, including new products that are continually being introduced into the marketplace. New entrants into the marketplace, as well as consolidation within the industry, have contributed to and are expected to intensify the competitive environment. In addition, the rapid pace of change as the industry evolves towards a consumer-focused retail marketplace, including Public and Private Exchanges, and the increased use of technology to interact with members, providers and customers, increase the risks currently faced from new entrants and disruptive actions by existing competitors compared to prior periods. References to competitors and other companies throughout this Annual Report on Form 10-K, including the information incorporated by reference herein, are for illustrative or comparison purposes only

and do not indicate that these companies are the Company's or any segment's only competitors or closest competitors.

The Company believes that the significant factors that distinguish competing health plans include the perceived overall quality (including accreditation status), quality of service, comprehensiveness of coverage, cost (including premium rates, provider discounts and member out-of-pocket costs), product design, financial stability and ratings, breadth and quality of

provider networks, ability to offer different provider network options, providers available in such networks, and quality of member support and care management programs. The Company believes that it is competitive on each of these factors. The Company's ability to increase the number of persons covered by its health plans or to increase Health Care Benefits segment revenues is affected by its ability to differentiate itself from its competitors on these factors. Competition may also affect the availability of services from health care providers, including primary care physicians, specialists and hospitals.

Insured products compete with local and regional health care benefits plans, health care benefits and other plans sponsored by other large commercial health care benefit insurance companies, health system owned health plans, new entrants into the marketplace and numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association. The largest competitor in Medicare products is Original Medicare. Additional Health Care Benefits segment competitors include other types of medical and dental provider organizations, various specialty service providers (including PBM services providers), health care consultants, financial services companies, integrated health care delivery organizations (networks of providers who also coordinate administrative services for and assume insurance risk of their members), third party administrators ("TPAs"), HIT companies and, for certain plans, programs sponsored by the federal or state governments. Emerging competitors include start up health care benefits plans, technology companies, provider-owned health plans, new joint ventures (including not-for-profit joint ventures among firms from multiple industries), technology firms, financial services firms that are distributing competing products on their proprietary Private Exchanges, and consulting firms that are distributing competing products on their proprietary Private Exchanges, as well as non-traditional distributors such as retail companies. The Company's ability to increase the number of persons enrolled in Insured Commercial Medical products also is affected by the desire and ability of employers to self-fund their health coverage.

The Health Care Benefits segment's ASC plans compete primarily with other large commercial health care benefit companies, numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association and TPAs.

The Health Care Benefits segment's international products compete with local, global and United States based health plans and commercial health care benefit insurance companies, many of whom have a longer operating history and better brand recognition and greater marketplace presence in one or more geographies.

The provider solutions and HIT marketplaces and products are evolving rapidly. The Company competes for provider solutions and HIT business with other large health plans and commercial health care benefit insurance companies as well as information technology companies and companies that specialize in provider solutions and HIT. Many information technology product competitors have longer operating histories, better brand recognition, greater marketplace presence and more experience in developing innovative products.

In addition to competitive pressures affecting the Company's ability to obtain new customers or retain existing customers, the Health Care Benefits segment's medical membership has been and may continue to be adversely affected by adverse and/or uncertain economic conditions and reductions in workforce by existing customers due to adverse and/or uncertain general economic conditions, especially in the United States and industries where such membership is concentrated.

Health Care Benefits Reinsurance

The Company currently has several reinsurance agreements with non-affiliated insurers that relate to Health Care Benefits insurance policies. The Company entered into these contracts to reduce the risk of catastrophic losses which in turn reduces capital and surplus requirements. The Company frequently evaluates reinsurance opportunities and refines its reinsurance and risk management strategies on a regular basis.

Corporate/Other Segment

The Company presents the remainder of its financial results in the Corporate/Other segment, which consists of:

- Management and administrative expenses to support the overall operations of the Company, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments; and

- Products for which the Company no longer solicits or accepts new customers such as large case pensions and long-term care insurance products.

Generic Sourcing Venture

The Company and Cardinal Health, Inc. ("Cardinal") each have a 50% ownership in Red Oak Sourcing, LLC ("Red Oak"), a generic pharmaceutical sourcing entity. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak. Red Oak does not own or hold inventory on behalf of either company.

Working Capital Practices

The Company funds the growth of its businesses through a combination of cash flow from operations, commercial paper and other short-term borrowings, proceeds from sale-leaseback transactions and long-term borrowings. For additional information on the Company's working capital practices, see the caption "Management's Discussion and Analysis of Financial Condition and Results of Operations - Liquidity and Capital Resources" in the Annual Report, which section is incorporated by reference herein. The majority of the Retail/LTC segment non-pharmacy revenues are paid in cash, or with debit or credit cards. Managed care organizations, pharmacy benefit managers, government funded health care programs, commercial employers and other third party insurance programs, which represent the vast majority of the Company's consolidated pharmacy revenues, typically settle in less than 30 days. With the exception of the Medicare Part D services, described further below, the remainder of the Company's consolidated pharmacy revenues are paid in cash, or with debit or credit cards. Employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans (with the exception of Medicare Part D services, which are described below), labor groups and expatriates, which represent the vast majority of Health Care Benefits segment revenues, typically settle in less than 30 days. As a provider of Medicare Part D services, the Company contracts annually with CMS. Utilization of services each plan year results in the accumulation of either a receivable from or a payable to CMS. The timing of settlement of the receivable or payable with CMS takes several quarters which impacts working capital from year to year.

Colleague Development

As of December 31, 2018, the Company employed approximately 295,000 colleagues in 50 states, the District of Columbia, Puerto Rico and a number of countries outside the United States. To deliver the highest levels of service to customers, the Company devotes considerable time and attention to its people and service standards. The Company emphasizes attracting and training knowledgeable, friendly and helpful associates to work in the organization.

Intellectual Property

The Company has registered and/or applied to register a variety of trademarks and service marks used throughout its businesses, as well as domain names, and relies on a combination of copyright, patent, trademark and trade secret laws, in addition to contractual restrictions, to establish and protect the Company's proprietary rights. The Company regards its intellectual property as having significant value in the Pharmacy Services, Retail/LTC and Health Care Benefits segments. The Company is not aware of any facts that could materially impact the continuing use of any of its intellectual property.

Government Regulation

Overview

The Company's operations are subject to comprehensive federal, state and local laws and regulations and comparable multiple levels of international regulation in the jurisdictions in which it does business. There also continues to be a heightened level of review and/or audit by federal, state and international regulators of the health and related benefits industry's business and reporting practices. In addition, many of the Company's PBM clients and the Company's payors in the Retail/LTC Segment, including insurers, Medicare Part D plans, Managed Medicaid plans and managed care organizations ("MCOs"), are themselves subject to extensive regulations that affect the design and implementation of prescription drug benefit plans that they sponsor. Similarly, the Company's LTC clients, such as skilled nursing facilities, are subject to government regulations, including many of the same government regulations to which the Company is subject.

The laws and rules governing the Company's businesses and interpretations of those laws and rules continue to expand and become more restrictive each year and are subject to frequent change. The application of these complex legal and regulatory requirements to the detailed operation of the Company's businesses creates areas of uncertainty. Further, there are numerous proposed health care laws and regulations at the federal, state and international levels, some of which could adversely affect the Company's businesses if they are enacted. The Company cannot predict whether pending or future federal or state legislation or

court proceedings, including future United States Congressional appropriations, will change various aspects of the industries in which it operates or the health care industry generally or the impact those changes will have on the Company's businesses, results of operations and/or cash flows, but the effects could be materially adverse. Any failure or alleged failure to comply with applicable laws and regulations as summarized below, or any adverse applications or interpretations of, or changes in, the laws and regulations affecting the Company and/or its businesses, could have a material adverse effect on the Company's results of operations, financial condition and/or cash flows. See Item 3, "Legal Proceedings" for further information.

The Company cannot give any assurances that its businesses, financial condition, results of operations and/or cash flows will not be materially adversely affected, or that it will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations, including the laws and regulations described in this Government Regulation section, as they may relate to one or more of the Company's businesses, one or more of the industries in which it operates and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's businesses, one or more of the industries in which it operates and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in other pending or future legal proceedings against the Company or affecting one or more of the industries in which it operates and/or the health care industry generally.

Laws and Regulations Related to Multiple Segments of the Company's Business

Laws Related to Reimbursement by Government Programs - The Company is subject to various federal and state laws concerning its submission of claims for reimbursement by Medicare, Medicaid and other federal and state government-sponsored health care programs. Potential sanctions for violating these laws include recoupment or reduction of government reimbursement amounts, civil penalties, treble damages, and exclusion from participation in government health care programs. Such laws include the federal False Claims Act (the "False Claims Act"), the federal anti-kickback statute, state false claims acts and anti-kickback statutes in most states, the federal "Stark Law" and related state laws. In particular, the False Claims Act prohibits intentionally submitting, conspiring to submit, or causing to be submitted, false claims, records, or statements to the federal government, or intentionally failing to return overpayments, in connection with reimbursement by federal government programs. In addition, any claim for government reimbursement also violates the False Claims Act where it results from a violation of the federal anti-kickback statute.

Both federal and state false claims laws permit private individuals to file qui tam or "whistleblower" lawsuits on behalf of the federal or state government. Participants in the health and related benefits industry, including the Company, frequently are subject to actions under the False Claims Act or similar state laws. The federal Stark Law generally prohibits physicians from referring Medicare or Medicaid beneficiaries for certain services, including outpatient prescription drugs, to any entity with which the physician, or an immediate family member of the physician, has a financial relationship. The Stark Law further prohibits the entity receiving a prohibited referral from presenting a claim for reimbursement by Medicare or Medicaid for services furnished pursuant to the prohibited referral. Various states have enacted similar laws.

The ACA - The ACA made broad-based changes to the United States health care system. If the ACA is not further amended, repealed or replaced, certain of its components will continue to be phased in until 2022. While the Company anticipates continued efforts in 2019 and beyond to invalidate, modify, repeal or replace the ACA, the Company expects aspects of the ACA to continue to significantly impact its business operations and results of operations, including pricing, medical benefit ratios ("MBRs") and the geographies in which the Company's products are available.

While most of the significant aspects of the ACA became effective during or prior to 2014, parts of the ACA continue to evolve through the promulgation of executive orders, regulations and guidance as well as ongoing litigation. Additional changes to the ACA and those regulations and guidance at the federal and/or state level are likely, and those changes are likely to be significant. Growing federal and state budgetary pressures make it more likely that any changes, including changes at the state level in response to changes to, or invalidation, repeal or replacement of, the ACA and/or changes in the funding levels and/or payment mechanisms of federally supported benefit programs, will be adverse to us. For example, if any elements of the ACA are invalidated or repealed at the federal level, the

Company expects that some states would seek to enact similar requirements, such as prohibiting pre-existing condition exclusions, prohibiting rescission of insurance coverage, requiring coverage for dependents up to age 26, requiring guaranteed renewability of insurance coverage and prohibiting lifetime limits on insurance coverage.

The expansion of health care coverage contemplated by the ACA is being funded in part by reductions to the reimbursements the Company and other health plans are paid by the federal government for Medicare members, among other sources. While not all-inclusive, the following are some of the key provisions of the ACA (assuming it continues to be implemented in its current form) that become effective on or after January 1, 2019. The Company continues to evaluate these provisions and the related regulations and regulatory guidance to determine the impact that they will have on its business operations and results of operations:

- The imposition on the Company and other health insurers, health plans and other market participants of significant fees, assessments and taxes, including an annual non-tax deductible industry-wide HIF that was $14.3 billion for 2018 and has been suspended for 2019. As currently enacted, the HIF will apply for 2020, be higher for 2020 than for 2018 and increase in 2021 and annually thereafter.
- A non-tax deductible 40% excise tax on employer-sponsored health care benefits above a certain threshold beginning in 2022.
- Reduced funding for Medicaid expansion, which began in 2017.

The ACA also specifies minimum medical loss ratios ("MLRs") for Commercial and Medicare Insured products, specifies features required to be included in Commercial benefit designs, limits Commercial individual and small group rating and pricing practices, encourages additional competition (including potential incentives for new market entrants) and significantly increases federal and state oversight of health plans, including regulations and processes that could delay or limit the Company's ability to appropriately increase its health plan premium rates. This in turn could adversely affect the Company's ability to continue to participate in certain product lines and/or geographies that it serves today.

Potential repeal of the ACA, ongoing legislative, regulatory and administrative policy changes to the ACA, the results of congressional and state level elections, the December 2018 U.S. District Court decision invalidating the ACA and other pending litigation challenging aspects of the law or funding for the law and federal budget negotiations continue to create uncertainty about the ultimate impact of the ACA. The pending litigation challenging the ACA includes challenges by various states of the federal government's decision to curtail payments related to the Cost-Sharing Subsidy Program. The time frame for conclusion and final outcome and ultimate impact of this litigation are uncertain. Given the inherent difficulty of foreseeing the nature and scope of future changes to the ACA and how states, businesses and individuals will respond to those changes, the Company cannot predict the impact on it of future changes to the ACA. It is reasonably possible that invalidation, repeal or replacement of or other changes to the ACA and/or states' responses to such changes, in the aggregate, could have a significant adverse effect on the Company's businesses, results of operations and cash flows.

Medicare Regulation - The Company's Medicare Advantage products compete directly with Original Medicare and Medicare Advantage products offered by other Medicare Advantage organizations and Medicare Supplement products offered by other insurers. The Company's Medicare PDP and Medicare Supplement products are products that Medicare beneficiaries who are enrolled in Original Medicare purchase to enhance their Original Medicare coverage.

The Company continues to expand the number of counties in which it offers Medicare products. The Company expects to further expand its Medicare service area and products in 2019 and is seeking to substantially grow its Medicare membership, revenue and results of operations over the next several years, including through growth in Medicare Supplement products. The anticipated organic expansion of the Medicare service area and Medicare products offered and the Medicare-related provisions of the ACA significantly increase the Company's exposure to funding and regulation of, and changes in government policy with respect to and/or funding or regulation of, the various Medicare programs in which the Company participates, including changes in the amounts payable to us under those programs and/or new reforms or surcharges on existing programs. For example, since the 2014 contract year, the ACA has required minimum MLRs for Medicare Advantage and Medicare Part D plans of 85%. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage contract pays rebates for five consecutive years, it will be terminated by CMS.

The Company's Medicare Advantage and PDP products are heavily regulated by CMS. The regulations and contractual requirements applicable to the Company and other private participants in Medicare programs are

complex, expensive to comply with and subject to change. For example, in the second quarter of 2014, CMS issued a final rule implementing the ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. The precise interpretation, impact and legality of this rule are not clear and are subject to pending litigation. Payments the Company receives from CMS for its Medicare Advantage and Part D businesses also are subject to risk adjustment based on the health status of the individuals enrolled. Elements of that risk adjustment mechanism continue to be challenged by the DOJ, the Office of Inspector General ("OIG") and CMS itself. Substantial changes in the risk adjustment mechanism, including changes

that result from enforcement or audit actions, could materially affect the fairness of the Company's Medicare reimbursement, require the Company to raise prices or reduce the benefits offered to Medicare beneficiaries, and potentially limit the Company's (and the industry's) participation in the Medicare program.

The Company has invested significant resources to comply with Medicare standards, and its Medicare compliance efforts will continue to require significant resources. CMS may seek premium and other refunds, prohibit the Company from continuing to market and/or enroll members in or refuse to passively enroll members in one or more of the Company's Medicare or Medicare-Medicaid demonstration (historically known as "dual eligible") plans, exclude us from participating in one or more Medicare, dual eligible or dual eligible special needs plan programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS regulations or its Medicare contractual requirements. The Company's Medicare Supplement products are regulated at the state level.

CMS regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare Advantage and PDP beneficiaries. For example, CMS currently conducts risk adjustment data validation ("RADV") audits of a subset of Medicare Advantage contracts for each contract year. Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various years for RADV audit. The OIG also is auditing the Company's risk adjustment data and that of other companies, and the Company expects CMS and the OIG to continue auditing risk adjustment data. The Company also has received Civil Investigative Demands ("CIDs") from, and provided documents and information to, the Civil Division of the DOJ in connection with a current investigation of its patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

On October 26, 2018, CMS issued proposed rules related to, among other things, changes to the RADV audit methodology established by CMS in 2012, CMS projects that the changes to the RADV audit methodology would increase its recoveries from Medicare Advantage plans as a result of RADV audits. CMS has requested comments on the proposed rules, including whether the proposed RADV rule change should apply retroactively to audits of Medicare Advantage plans for contract year 2011 and forward. The Company is evaluating the potential adverse effect, which could be material, on the Company's results of operations, financial condition, and cash flows if the proposed RADV rule change were adopted as proposed. CMS also has announced its intent to use third party auditors to attain its ultimate goal of subjecting all Medicare Advantage contracts to either a comprehensive or a targeted RADV audit for each contract year.

A portion of each Medicare Advantage plan's reimbursement is tied to the plan's "star ratings." The star rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management, compliance and overall customer satisfaction. Only Medicare Advantage plans with an overall star rating of four or more stars (out of five stars) are eligible for a quality bonus in their basic premium rates. As a result, the Company's Medicare Advantage plans' results of operations in 2019 and going forward will be significantly affected by their star ratings. The Company's star ratings and past performance scores are adversely affected by the compliance issues that arise each year in its Medicare operations. CMS released the Company's 2019 star ratings in October 2018. The Company's 2019 star ratings will be used to determine which of its Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2020. Based on the Company's membership at December 31, 2018, 79% of its Medicare Advantage members were in plans with 2019 star ratings of at least 4.0 stars. CMS will release updated stars ratings in October 2019 that will be used to determine which Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2021. CMS also gives PDPs star ratings which affect PDP's enrollment and result in contract termination if the PDP is rated less than three stars for three consecutive years. CMS continues to revise its star ratings system to make it harder to achieve four stars or more. Despite the Company's success in maintaining high star ratings and other quality measures for 2019 and the continuation of its improvement efforts, there can be no assurances that it will be successful in maintaining or improving its star ratings in future years. Accordingly, the Company's Medicare Advantage plans may not be eligible for full level quality bonuses, which could adversely affect the benefits such plans can offer, reduce membership and/or reduce profit margins.

Overall, the Company projects the benchmark payment rates in CMS's April 2018 final notice detailing final Medicare Advantage benchmark payment rates for 2019 (the "Final Notice") will increase funding for the Company's Medicare Advantage business, excluding the impact of coding trend, by approximately 2.5 percent in 2019 compared to 2018. This 2019 rate increase only partially offsets the challenge the Company faces from the impact of the increasing cost of medical care (including prescription medications) and CMS local and national

coverage decisions that require the Company to pay for services and supplies that are not factored into the Company's bids. The federal government may seek to impose restrictions on the configuration of pharmacy or other provider networks for Medicare Advantage and/or PDP plans, or otherwise restrict the ability of these plans to alter benefits, negotiate prices or establish other terms to improve affordability or maintain viability of products. The Company currently believes that the payments received and will receive in the near term are adequate to justify

the Company's continued participation in the Medicare Advantage and PDP programs, although there are economic and political pressures to continue to reduce spending on the program, and this outlook could change.

Going forward, the Company expects CMS, the OIG, the DOJ, other federal agencies and the United States Congress to continue to scrutinize closely each component of the Medicare program (including Medicare Advantage, PDP, demonstration projects such as Medicare-Medicaid plans and provider network access and adequacy), modify the terms and requirements of the program and possibly seek to recast or limit private insurers' role. It is not possible to predict the outcome of this Congressional or regulatory activity, any of which could adversely affect the Company.

Anti-Remuneration Laws - Federal law prohibits, among other things, an entity from knowingly and willfully offering, paying, soliciting or receiving, subject to certain exceptions and "safe harbors," any remuneration to induce the referral of individuals or the purchase, lease or order of items or services for which payment may be made under Medicare, Medicaid or certain other federal and state health care programs. A number of states have similar laws, some of which are not limited to services paid for with government funds. Sanctions for violating these federal and state anti-remuneration laws may include imprisonment, criminal and civil fines, and exclusion from participation in Medicare, Medicaid and other federal and state government-sponsored health care programs. Companies involved in public health care programs such as Medicare and/or Medicaid are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The Company has invested significant resources to comply with Medicare and Medicaid program standards. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that the Company's compliance efforts in this area will continue to require significant resources.

Antitrust and Unfair Competition - The Federal Trade Commission ("FTC") investigates and prosecutes practices that are "unfair trade practices" or "unfair methods of competition." Numerous lawsuits have been filed throughout the United States against pharmaceutical manufacturers, retail pharmacies and/or PBMs under various federal and state antitrust and unfair competition laws challenging, among other things: (i) brand name drug pricing and rebate practices of pharmaceutical manufacturers, (ii) the maintenance of retail or specialty pharmacy networks by PBMs, and (iii) various other business practices of PBMs and retail pharmacies. To the extent that the Company appears to have actual or potential market power in a relevant market or CVS Pharmacy, CVS Specialty or MinuteClinic plays a unique or expanded role in a PBM or Health Care Benefits segment product offering, the Company's business arrangements and uses of confidential information may be subject to heightened scrutiny from an anti-competitive perspective and possible challenge by state or federal regulators or private parties.

Privacy and Confidentiality Requirements - Many of the Company's activities involve the receipt, use and disclosure by the Company of personally identifiable information ("PII") as permitted in accordance with applicable federal and state privacy and data security laws, which require organizations to provide appropriate privacy and security safeguards for such information. In addition to PII, the Company uses and discloses de-identified data for analytical and other purposes when permitted. Additionally, there are industry standards for handling credit card data known as the Payment Card Industry Data Security Standard, which are a set of requirements designed to help ensure that entities that process, store or transmit credit card information maintain a secure environment. Certain states have incorporated these requirements into state laws or enacted other requirements relating to the use and/or disclosure of PII.

The federal Health Insurance Portability and Accountability Act of 1996 and the regulations issued thereunder (collectively, "HIPAA"), as further modified by the American Recovery and Reinvestment Act of 2009 ("ARRA") impose extensive requirements on the way in which health plans, health care providers, health care clearinghouses (known as "covered entities") and their business associates use, disclose and safeguard protected health information ("PHI"). Further, ARRA requires us and other covered entities to report any breaches of PHI to impacted individuals and to the United States Department of Health and Human Services ("HHS") and to notify the media in any states where 500 or more people are impacted by the unauthorized release or use of or access to PHI. Criminal penalties and civil sanctions may be imposed for failing to comply with HIPAA standards. The Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), enacted as part of ARRA, amended HIPAA to impose additional restrictions on third-party funded communications using PHI and the receipt of remuneration in exchange for PHI. The HITECH Act also extended HIPAA privacy and security requirements and penalties directly to business associates. HHS has begun to audit health plans, providers and other parties to enforce HIPAA compliance, including with respect to data security.

In addition to HIPAA, state health privacy laws apply to the extent they are more protective of individual privacy than is HIPAA, including laws that place stricter controls on the release of information relating to specific diseases or conditions and requirements to notify members of unauthorized release or use of or access to PHI. States also have adopted regulations to implement provisions of the Financial Modernization Act of 1999 (also known as the Gramm-Leach-Bliley Act ("GLBA")) which generally require insurers, including health insurers, to provide customers with notice regarding how their non-public

personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a non-affiliated third party. Like HIPAA, GLBA sets a "floor" standard, allowing states to adopt more stringent requirements governing privacy protection. Complying with additional state requirements requires us to make additional investments beyond those the Company has made to comply with HIPAA and GLBA.

The Cybersecurity Information Sharing Act of 2015 encourages organizations to share cyber threat indicators with the federal government and, among other things, directs HHS to develop a set of voluntary cybersecurity best practices for organizations in the health care industry. In addition, states have begun to enact more comprehensive privacy laws and regulations addressing consumer rights to data protection or transparency. States also are starting to issue regulations and proposed regulations specifically related to cybersecurity, such as the regulations issued by the New York Department of Financial Services. Complying with conflicting cybersecurity regulations, which may differ from state to state, requires significant resources. In addition, differing approaches to state privacy and/or cyber-security regulation and varying enforcement philosophies may materially and adversely affect the Company's ability to standardize its products and services across state lines. Widely-reported large scale commercial data breaches in the United States and abroad increase the likelihood that additional data security legislation will be considered by additional states. These legislative and regulatory developments will impact the design and operation of the Company's businesses, its privacy and security strategy and its web-based and mobile assets.

Finally, Public Exchanges are required to adhere to privacy and security standards with respect to PII, and to impose privacy and security standards that are at least as protective of PII as those the Public Exchange has implemented for itself or non-Public Exchange entities, which include insurers offering plans through the Public Exchanges and their designated downstream entities, including PBMs and other business associates. These standards may differ from, and be more stringent than, HIPAA.

Consumer Protection Laws - The federal government has many consumer protection laws, such as the Federal Trade Commission Act, the Federal Postal Service Act, the Consumer Product Safety Act and the FTC's Telemarketing Sales Rule. Most states also have similar consumer protection laws. In addition, the federal government and most states have adopted laws and/or regulations requiring places of public accommodation, health care services and other goods and services to be accessible to people with disabilities. These consumer protection and accessibility laws and regulations have been the basis for investigations, lawsuits and multistate settlements relating to, among other matters, the marketing of loyalty programs, and health care products and services, pricing accuracy, expired front store products, financial incentives provided by drug manufacturers to pharmacies in connection with therapeutic interchange programs, disclosures related to how personal data is used and protected and the accessibility of goods and services to people with disabilities. As a result of the Company's direct-to-consumer activities, including mobile and web-based solutions offered to members and to other consumers, the Company also is subject to federal and state regulations applicable to electronic communications and to other general consumer protection laws and regulations. For example, the California Consumer Privacy Act will become effective in 2020, and the Company expects additional federal and state regulation of consumer privacy protection to be enacted in 2019. The Company expects these new laws and regulations to impact the design of its products and services and the management and operation of its businesses and to increase its compliance costs.

Telemarketing and Other Outbound Contacts - Certain federal and state laws, such as the Telephone Consumer Protection Act, give the FTC, Federal Communications Commission and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Pharmacy and Professional Licensure and Regulation - The Company is subject to a variety of intersecting federal and state statutes and regulations that govern the wholesale distribution of drugs; operation of retail, specialty, infusion, LTC and mail order pharmacies; licensure of facilities and professionals, including pharmacists, technicians, nurses and other healthcare professionals; registration of facilities with the United States Drug Enforcement Administration ("DEA") and analogous state agencies that regulate controlled substances; packaging, storing, shipping and tracking of pharmaceuticals; repackaging of drug products; labeling, medication guides and other consumer disclosures; interactions with prescribers and health care professionals; compounding of prescription medications; dispensing of controlled and non-controlled substances; counseling of patients; transfers of prescriptions; advertisement of prescription products and pharmacy services; security; inventory control; recordkeeping; reporting to Boards of Pharmacy, the United States Food and Drug Administration ("FDA"), the

Consumer Product Safety Commission, the DEA and related state agencies; and other elements of pharmacy practice. Pharmacies are highly regulated and have contact with a wide variety of federal, state and local agencies, with various powers to investigate, inspect, audit or solicit information, including Boards of Pharmacy and Nursing, the DEA, the FDA, the United States Department of Justice, HHS and others. Many of these agencies have broad enforcement powers, conduct audits on a regular

basis, can impose substantial fines and penalties, and may revoke the license, registration or program enrollment of a facility or professional.

State Insurance, HMO and Insurance Holding Company Regulation - A number of states regulate affiliated groups of insurers and HMOs such as the Company under holding company statutes. These laws may, among other things, require prior regulatory approval of dividends and material intercompany transfers of assets and transactions between the regulated companies and their affiliates, including their parent holding companies. The Company expects the states in which its insurance and HMO subsidiaries are licensed to continue to expand their regulation of the corporate governance and internal control activities of its insurance companies and HMOs. Changes to state insurance, HMO and/or insurance holding company laws or regulations or changes to the interpretation of those laws or regulations, including due to regulators' increasing concerns regarding insurance company and/or HMO solvency due, among other things, to recent and expected payor insolvencies, could negatively affect the Company's businesses in various ways, including through increases in solvency fund assessments, requirements that the Company hold greater levels of capital and/or delays in approving dividends from regulated subsidiaries.

PBM offerings of prescription drug coverage under certain risk arrangements may be subject to laws and regulations in various states. Such laws may require that the party at risk become licensed as an insurer, establish reserves or otherwise demonstrate financial viability. Laws that may apply in such cases include insurance laws and laws governing MCOs and limited prepaid health service plans.

The states of domicile of the Company's regulated subsidiaries have statutory risk-based capital, or "RBC", requirements for health and other insurance companies and HMOs based on the RBC Model Act. These RBC requirements are intended to assess the capital adequacy of life and health insurers and HMOs, taking into account the risk characteristics of a company's investments and products. The RBC Model Act sets forth the formula for calculating RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual company's business. In general, under these laws, an insurance company or HMO must submit a report of its RBC level to the insurance department or insurance commissioner of its state of domicile for each calendar year. At December 31, 2018, the RBC level of each of the Company's insurance and HMO subsidiaries was above the level that would require regulatory action.

For information regarding restrictions on certain payments of dividends or other distributions by the Company's HMO and insurance company subsidiaries, see Note 12 ''Shareholders' Equity'' contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

The holding company laws for the states of domicile of certain of the Company's subsidiaries also 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 (such as the Company's parent company, CVS Health Corporation) that controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would control the insurance holding company. Control is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person.

Certain states have laws that prohibit submitting a false claim or making a false record or statement in order to secure reimbursement from an insurance company. These state laws vary, and violation of them may lead to the imposition of civil or criminal penalties.

Government Agreements and Mandates - The Company and/or its various affiliates are subject to certain consent decrees, settlement and other agreements, corrective action plans and corporate integrity agreements with various federal, state and local authorities relating to such matters as privacy practices, controlled substances, Medicare Part D prescription drug plans, expired products, environmental and safety matters, marketing and advertising practices, PBM, LTC and other pharmacy operations and various other business practices. Certain of these agreements contain ongoing reporting, monitoring and/or other compliance requirements for the Company. Failure to meet the Company's obligations under these agreements could result in civil or criminal remedies, financial penalties, administrative remedies, and/or exclusion from participation in federal health care programs.

Environmental and Safety Regulation - The Company's businesses are subject to various federal, state and local laws, regulations and other requirements pertaining to protection of the environment, public health and employee

safety, including, for example, regulations governing the management of hazardous substances, the cleaning up of contaminated sites, and the maintenance of safe working conditions in the Company's stores, distribution centers and other facilities. Governmental agencies at the federal, state and local levels continue to focus on the retail and health care sectors' compliance with such laws

and regulations, and have at times pursued enforcement activities. Any failure to comply with these regulations could result in fines or other sanctions by government authorities.

ERISA Regulation - The Employee Retirement Income Security Act of 1974 ("ERISA"), provides for comprehensive federal regulation of certain employee pension and benefit plans, including private employer and union sponsored health plans and certain other plans that contract with us to provide PBM services. In general, the Company assists plan sponsors in the administration of their health benefit plans, including the prescription drug benefit portion of those plans, in accordance with the plan designs adopted by the plan sponsors. In addition, the Company may have fiduciary duties where it has specifically contracted with a plan sponsor to accept limited fiduciary responsibility, such as for the adjudication of initial prescription drug benefit claims and/or the appeals of denied claims under a plan. In addition to its fiduciary provisions, ERISA imposes civil and criminal liability on service providers to health plans and certain other persons if certain forms of illegal remuneration are made or received. These provisions of ERISA are broadly written and their application to specific business practices is often uncertain.

Some of the Company's health and related benefits and large case pensions products and services and related fees also are subject to potential issues raised by judicial interpretations relating to ERISA. Under those interpretations, together with United States Department of Labor ("DOL") regulations, the Company may have ERISA fiduciary duties with respect to PBM members and/or certain general account assets held under contracts that are not guaranteed benefit policies. As a result, certain transactions related to those general account assets are subject to conflict of interest and other restrictions, and the Company must provide certain disclosures to policyholders annually. The Company must comply with these restrictions or face substantial penalties.

In addition, ERISA generally preempts all state and local laws that relate to employee benefit plans, but the extent of the pre-emption continues to be reviewed by courts.

Other Legislative Initiatives and Regulatory Initiatives - The United States federal and state governments, as well as governments in other countries where the Company does business, continue to enact and seriously consider many broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system and the Company's businesses. For example:

- Under the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012 significant, automatic across-the-board budget cuts (known as sequestration) began in March 2013, including Medicare spending cuts of not more than 2% of total program costs per year through 2024. Significant uncertainty remains as to whether and how the United States Congress will proceed with actions that create additional federal revenue and/or with entitlement reform. The Company cannot predict future federal Medicare or federal or state Medicaid funding levels or the impact that future federal or state budget actions or entitlement program reform, if it occurs, will have on the Company's businesses, operations or results of operations, but the effects could be materially adverse, particularly on the Company's Medicare and/or Medicaid revenues, MBRs and results of operations.

- The European Union's ("EU's") General Data Protection Regulation ("GDPR") began to apply across the EU during 2018.

- Other significant legislative and/or regulatory measures which are or recently have been under consideration include the following:

    - Elimination of the payment of manufacturer's rebates on prescription drugs to PBMs, PDPs and Managed Medicaid organizations in connection with federally funded health care programs. In January 2019, HHS proposed regulations that would exclude such rebates from the safe harbor that currently is available for such payments under the federal anti-kickback statute.

    - Imposing requirements and restrictions on the design and/or administration of pharmacy benefits plans offered by the Company's and its clients' health plans and/or its PBM clients and/or the services the Company provides to those clients, including restricting or eliminating the use of formularies for prescription drugs; restricting the Company's ability to require members to obtain drugs through a home delivery or specialty pharmacy; restricting the Company's ability to place certain specialty or other drugs in the higher cost tiers of its pharmacy formularies; restricting the Company's ability to

make changes to drug formularies and/or clinical programs; limiting or eliminating rebates on pharmaceuticals; requiring the use of up front purchase price discounts on pharmaceuticals in lieu of rebates; restricting the Company's ability to configure its health plan and retail pharmacy networks; and restricting or eliminating the use of certain drug pricing methodologies.

- Increased federal or state government regulation of, or involvement in, the pricing and/or purchasing of drugs.

- Restricting the Company's ability to limit providers' participation in its networks and/or remove providers from its networks by imposing network adequacy requirements or otherwise (including in its Medicare and Commercial Health Care Benefits products).

- Imposing assessments on (or to be collected by) health plans or health carriers, which may or may not be passed onto their customers. These assessments may include assessments for insolvency, the uninsured, uncompensated care, Medicaid funding or defraying health care provider medical malpractice insurance costs.

- Mandating coverage by the Company and its clients' health plans for additional conditions and/or specified procedures, drugs or devices (for example, high cost pharmaceuticals, experimental pharmaceuticals and oral chemotherapy regimens).

- Regulating electronic connectivity.

- Mandating or regulating the disclosure of provider fee schedules and other data about the Company's payments to providers.

- Mandating or regulating disclosure of provider outcome and/or efficiency information.

- Prescribing or limiting members' financial responsibility for health care or other covered services they utilize.

- Assessing the medical device status of HIT products and/or solutions, mobile consumer wellness tools and clinical decision support tools, which may require compliance with FDA requirements in relation to some of these products, solutions and/or tools.

- Imposing payment levels for services rendered to the Company's members by providers who do not have contracts with the Company.

- Restricting the ability of employers and/or health plans to establish or impose member financial responsibility.

- Amending or supplementing ERISA to impose greater requirements on PBMs, the administration of employer-funded benefit plans or limit the scope of current ERISA pre-emption, which would among other things expose us and other health plans to expanded liability for punitive and other extra-contractual damages and additional state regulation.

It is uncertain whether the Company can counter the potential adverse effects of such potential legislation or regulation on its results of operations or cash flows, including whether it can recoup, through higher premium rates, expanded membership or other measures, the increased costs of mandated coverage or benefits, assessments, fees, taxes or other increased costs, including the cost of modifying its systems to implement any enacted legislation or regulations.

The Company's businesses also may be affected by other legislation and regulations. The Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Financial Reform Act") creates incentives for whistleblowers to speak directly to the government rather than utilizing internal compliance programs and reduces the burden of proof under the Foreign Corrupt Practices Act of 1977 (the "FCPA"). There also are laws and regulations that set standards for the escheatment of funds to states.

Health savings accounts, health reimbursement arrangements and flexible spending accounts and certain of the tax, fee and subsidy provisions of the ACA also are regulated by the United States Department of the Treasury and the Internal Revenue Service.

The Company also may be adversely affected by court and regulatory decisions that expand or revise the interpretations of existing statutes and regulations or impose medical malpractice or bad faith liability. Federal and state courts continue to consider cases, and federal and state regulators continue to issue regulations and interpretations, addressing bad faith liability for denial of medical claims, the scope of ERISA's fiduciary duty requirements, the scope of the False Claims Act and the pre-emptive effect of ERISA on state laws.

Contract Audits - The Company is subject to audits of many of its contracts, including its PBM client contracts, its PBM rebate contracts, its PBM network contracts, its contracts relating to Medicare Advantage, and/or Medicare Part D, the agreements the Company's pharmacies enter into with other payors, its Medicaid contracts and its customer contracts. Because some of the Company's contracts are with state or federal governments or with entities contracted with state or federal agencies, audits of these agreements are often regulated by the federal or state agencies responsible for administering federal or state benefits programs, including those which operate Medicaid fee for service plans, Managed Medicaid plans, Medicare Part D plans or Medicare Advantage organizations.

Federal Employee Health Benefits Program - The Company's subsidiaries contract with the Office of Personnel Management (the "OPM") to provide managed health care services under the FEHB program in their service areas. These contracts with the

OPM and applicable government regulations establish premium rating arrangements for this program. OPM regulations require that community-rated FEHB plans meet a FEHB program-specific MLR by plan code and market. Managing to these rules is complicated by the simultaneous application of the minimum MLR standards and associated premium rebate requirements of the ACA. The Company also has a contractual arrangement with carriers for the FEHB program, such as the BlueCross BlueShield Association, to provide pharmacy services to federal employees, postal workers, annuitants, and their dependents under the Government-wide Service Benefit Plan, as authorized by the FEHB Act and as part of the FEHB program. Additionally, the Company manages certain FEHB plans on a "cost-plus" basis. These arrangements subject the Company to certain aspects of FEHB Act, and other federal regulations, such as the FEHB Acquisition Regulation, that otherwise would not be applicable to the Company. The OPM also is auditing the Company and its other contractors to, among other things, verify that plans meet their applicable FEHB program-specific MLR and the premiums established under the OPM's Insured contracts and costs allocated pursuant to the OPM's cost-based contracts are in compliance with the requirements of the applicable FEHB program. The OPM may seek premium refunds or institute other sanctions against the Company if it fails to comply with the FEHB program requirements.

Disease Management Services Regulation - The Company provides disease management programs to health plan and PBM plan members for complex medical conditions and arranges for those members to receive disease management programs for common medical conditions. State laws regulate the practice of medicine, the practice of pharmacy and the practice of nursing. Clinicians engaged in a professional practice in connection with the provision of disease management services must satisfy applicable state licensing requirements and must act within their scope of practice.

Third Party Administration and Other State Licensure Laws - Many states have licensure or registration laws governing certain types of administrative organizations, such as PPOs, TPAs and companies that provide utilization review services. Several states also have licensure or registration laws governing the organizations that provide or administer consumer card programs (also known as cash card or discount card programs).

International Regulation - The Company currently has insurance licenses in several foreign jurisdictions and does business directly or through local affiliations in numerous countries around the world. The Company is taking steps to be able to continue to serve customers in the European Economic Area following the United Kingdom's pending exit from the EU ("Brexit"). However, the impact of Brexit on the Company's international business and results of operations is uncertain.

The Company's international operations are subject to different, and sometimes more stringent, legal and regulatory requirements, which vary widely by jurisdiction, including anti-corruption laws; economic sanctions laws; various privacy, insurance, tax, tariff and trade laws and regulations; corporate governance, privacy, data protection (including the EU's General Data Protection Regulation which began to apply across the EU during 2018), data mining, data transfer, labor and employment, intellectual property, consumer protection and investment laws and regulations; discriminatory licensing procedures; compulsory cessions of reinsurance; required localization of records and funds; higher premium and income taxes; limitations on dividends and repatriation of capital; and requirements for local participation in an insurer's ownership. In addition, the expansion of the Company's operations into foreign countries increases the Company's exposure to the anti-bribery, anti-corruption and anti-money laundering provisions of United States law, including the FCPA, and corresponding foreign laws, including the U.K. Bribery Act 2010 (the "UK Bribery Act").

Anti-Corruption Laws - The FCPA prohibits offering, promising or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. The Company also is subject to applicable anti-corruption laws of the jurisdictions in which it operates. In many countries outside the United States, health care professionals are employed by the government. Therefore, the Company's dealings with them are subject to regulation under the FCPA. Violations of the FCPA and other anti-corruption laws may result in severe criminal and civil sanctions as well as other penalties, and the United States Securities and Exchange Commission (the "SEC") and the DOJ have increased their enforcement activities with respect to the FCPA. The UK Bribery Act is an anti-corruption law that is broader in scope than the FCPA and applies to all companies with a nexus to the United Kingdom. Disclosures of FCPA violations may be shared with the UK authorities, thus potentially exposing companies to liability and potential penalties in multiple jurisdictions. The Company has internal control policies and procedures and conducts training and compliance programs for its employees to deter prohibited practices. However, if the Company's employees or agents fail to comply with applicable laws governing

its international operations, it may face investigations, prosecutions and other legal proceedings and actions which could result in civil penalties, administrative remedies and criminal sanctions.

Anti-Money Laundering Regulations - Certain lines of the Company's businesses are subject to Treasury anti-money laundering regulations. Those lines of business have implemented anti-money laundering policies designed to insure their

compliance with the regulations. The Company also may be subject to anti-money laundering laws in non-U.S. jurisdictions where it operates.

Office of Foreign Assets Control - The Company also is subject to regulation by OFAC. OFAC administers and enforces economic and trade sanctions based on United States foreign policy and national security goals against targeted foreign countries and regimes, terrorists, international narcotics traffickers, those engaged in activities related to the proliferation of weapons of mass destruction, and other threats to the national security, foreign policy or economy of the United States. In addition, the Company may be subject to similar regulations in the non-U.S. jurisdictions in which it operates.

Laws and Regulations Related to the Pharmacy Services Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state and local statutes and regulations governing the operation of its Pharmacy Services segment specifically. Among these are the following:

PBM Laws and Regulation - Legislation seeking to regulate PBM activities in a comprehensive manner has been introduced or enacted in a number of states. This legislation could adversely affect the Company's ability to conduct business on commercially reasonable terms in states where the legislation is in effect. In addition, certain quasi-regulatory organizations, including the National Association of Boards of Pharmacy and the National Association of Insurance Commissioners ("NAIC") and the National Council of Insurance Legislators, have issued model regulations or may propose future regulations concerning PBMs and/or PBM activities. Similarly, credentialing organizations such as NCQA and URAC may establish voluntary standards regarding PBM, mail or specialty pharmacy activities. While the actions of these quasi-regulatory or standard-setting organizations do not have the force of law, they may influence states to adopt their requirements or recommendations and influence client requirements for PBM or specialty pharmacy services. Moreover, any standards established by these organizations could also impact the Company's health plan clients and/or the services provided to them and/or the Company's health plans.

The Company's PBM activities also are regulated directly and indirectly at the federal and state levels, including being subject to the False Claims Act and state false claims acts and federal and state anti-kickback laws. These laws and regulations govern, and proposed legislation and regulations may govern and/or further restrict, critical PBM practices, including disclosure, receipt and retention of rebates and other payments received from pharmaceutical manufacturers; use of, administration of and/or changes to drug formularies, maximum allowable cost ("MAC") list pricing, average wholesale prices ("AWPs") and/or clinical programs; the offering to plan sponsors of pricing that includes retail network "differential" or "spread" (i.e., a difference between the drug price charged to the plan sponsor by a PBM and the price paid by the PBM to the dispensing provider); disclosure of data to third parties; drug utilization management practices; the level of duty a PBM owes its customers; configuration of pharmacy networks; the operations of the Company's pharmacies (including audits of its pharmacies); disclosure of negotiated provider reimbursement rates; disclosure of fees associated with administrative service agreements and patient care programs that are attributable to members' drug utilization; and registration or licensing of PBMs. Failure by the Company or one of its PBM services suppliers to comply with these laws or regulations could result in material fines and/or sanctions and could have a material adverse effect on the Company's results of operations and/or cash flows.

PDPs and the Company's PBM service contracts, including those in which the Company assumes certain risks under performance guarantees or similar arrangements, are generally not subject to insurance regulation by the states. However, state departments of insurance are increasing their oversight of PBM activities due to legislation passing in several states requiring PBMs to register or obtain a license with the department. Rulemaking is either underway or has already taken place in a few states with the areas of focus on licensure requirements, pharmacy reimbursement for generics (MAC reimbursement) and pharmacy audits - most of which fall under the state insurance code.

Pharmacy Network Access Legislation - Medicare Part D and a majority of states now have some form of legislation affecting the Company's (and its health plans' and its health plan clients') ability to limit access to a pharmacy provider network or remove network providers. For example, certain "any willing provider" legislation may require the Company or its clients to admit a nonparticipating pharmacy if such pharmacy is willing and able to meet the plan's price and other applicable terms and conditions for network participation. These laws could negatively affect the services and economic benefits achievable through a limited pharmacy provider network. Also, a majority of states now have some form of legislation affecting the Company's ability (and the Company's and its

client health plans' ability) to conduct audits of network pharmacies regarding claims submitted to the Company for payment. These laws could negatively affect the Company's ability to recover overpayments of claims submitted by network pharmacies that the Company identifies through pharmacy audits.

Pharmacy Pricing Legislation - Several states have passed legislation regulating the Company's ability to manage and establish MACs for generic prescription drugs. MAC methodology is a common cost management practice used by private and public payors (including CMS) to pay pharmacies for dispensing generic prescription drugs. MAC prices specify the allowable reimbursement by a PBM for a particular strength and dosage of a generic drug that is available from multiple manufacturers but sold at different prices. State legislation can regulate the disclosure of MAC prices and MAC price methodologies, the kinds of drugs that a PBM can pay for at a MAC price, and the rights of pharmacies to appeal a MAC price established by a PBM. These laws could negatively affect the Company's ability to establish MAC prices for generic drugs.

Formulary and Plan Design Regulation - A number of government entities regulate the administration of prescription drug benefits. HHS regulates how Medicare Part D formularies are developed and administered, including requiring the inclusion of all drugs in certain classes and categories, subject to limited exceptions. Under the ACA, CMS imposes drug coverage requirements for health plans required to cover essential health benefits, including plans offered through federal or state Public Exchanges. Additionally, the NAIC and health care accreditation agencies like NCQA and URAC have developed model acts and standards for formulary development that are often incorporated into government requirements. Many states regulate the scope of prescription drug coverage, as well as the delivery channels to receive prescriptions, for insurers, MCOs and Medicaid managed care plans. The increasing government regulation of formularies could significantly affect the Company's ability to develop and administer formularies, networks and other plan design features on behalf of its insurer, MCO and other clients. Similarly, some states prohibit health plan sponsors from implementing certain restrictive design features. This regulation could limit or preclude (i) limited networks, (ii) a requirement to use particular providers, (iii) copayment differentials among providers and (iv) formulary tiering practices.

FDA Regulation - The FDA regulates the Company's compounding pharmacy and clinical research operations.

Laws and Regulations Related to the Retail/LTC Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state and local statutes and regulations governing the operation of its Retail/LTC segment specifically. Among these are the following:

FDA Regulation - The FDA generally has authority to, among other things, regulate the manufacture, distribution, sale and labeling of many products sold through retail pharmacies, including prescription drugs, over-the-counter medications, medical devices (including mobile medical devices), cosmetics, dietary supplements and certain food items. The FDA regulates the Company's activities as a distributor of store brand products.

Retail Clinics - States regulate retail clinics operated by nurse practitioners or physician assistants through physician oversight, clinic and lab licensure requirements and the prohibition of the corporate practice of medicine. A number of states have implemented or proposed laws or regulations that impact certain components of retail clinic operations such as physician oversight, signage, third party contracting requirements, bathroom facilities, and scope of services. These laws and regulations may affect the operation and expansion of the Company's owned and managed retail clinics.

Other Laws - Other federal, state and local laws and regulations also impact the Company's retail operations, including laws and regulations governing the practice of optometry, the practice of audiology, the provision of dietician services and the sale of durable medical equipment, contact lenses, eyeglasses, hearing aids and alcohol.

Laws and Regulations Related to the Health Care Benefits Segment

Overview - Differing approaches to state insurance regulation and varying enforcement philosophies may materially and adversely affect the Company's ability to standardize its Health Care Benefits products and services across state lines. These laws and regulations, including the ACA, restrict how the Company conducts its business and result in additional burdens and costs to the Company. Significant areas of governmental regulation include premium rates and rating methodologies, underwriting rules and procedures, required benefits, sales and marketing activities, provider rates of payment, restrictions on health plans' ability to limit providers' participation in their networks and/or remove providers from their networks and financial condition (including reserves and minimum capital or risk based capital requirements). These laws and regulations are different in each jurisdiction and vary from product to product.

Each health insurer and HMO must file periodic financial and operating reports with the states in which it does business. In addition, health insurers and HMOs are subject to state examination and periodic license renewal. Applicable laws also restrict the ability of the Company's regulated subsidiaries to pay dividends, and certain dividends require prior regulatory approval. In

addition, some of the Company's businesses and related activities may be subject to PPO, managed care organization, utilization review or TPA-related licensure requirements and regulations. These licensure requirements and regulations differ from state to state, but may contain provider network, contracting, product and rate, financial and reporting requirements. There also are laws and regulations that set specific standards for the Company's delivery of services, payment of claims, fraud prevention, protection of consumer health information, and payment for covered benefits and services.

Required Regulatory Approvals - The Company must obtain and maintain regulatory approvals to price, market and administer many of its Health Care Benefits products. Supervisory agencies, including CMS, the Center for Consumer Information and Insurance Oversight and the DOL, as well as state health, insurance, managed care and Medicaid agencies and state boards of pharmacy have broad authority to take one or more of the following actions:

- Grant, suspend and revoke the Company's licenses to transact business;
- Suspend or exclude the Company from participation in government programs;
- Suspend or limit the Company's authority to market products;
- Regulate many aspects of the products and services the Company offers, including the pricing and underwriting of many of its products and services;
- Assess damages, fines and/or penalties;
- Terminate the Company's contract with the government agency and/or withhold payments from the government agency to the Company;
- Impose retroactive adjustments to premiums and require the Company to pay refunds to the government, customers and/or members;
- Restrict the Company's ability to conduct acquisitions or dispositions;
- Require the Company to maintain minimum capital levels in its subsidiaries and monitor its solvency and reserve adequacy;
- Regulate the Company's investment activities on the basis of quality, diversification and other quantitative criteria; and/or
- Exclude the Company's plans from participating in Public Exchanges if they are deemed to have a history of "unreasonable" premium rate increases or fail to meet other criteria set by HHS or the applicable state.

The Company's operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time the Company receives subpoenas and other requests for information from, federal, state and international supervisory and enforcement agencies, attorneys general and other state, federal and international governmental authorities and legislators.

Commercial Product Pricing and Underwriting Restrictions - Pricing and underwriting regulation by states limits the Company's underwriting and rating practices and those of other health insurers, particularly for small employer groups, and varies by state. In general, these limitations apply to certain customer segments and limit the Company's ability to set prices for new or renewing groups, or both, based on specific characteristics of the group or the group's prior claim experience. In some states, these laws and regulations restrict the Company's ability to price for the risk it assumes and/or reflect reasonable costs in the Company's pricing.

The ACA expanded the premium rate review process by, among other things, requiring the Company's Commercial Insured rates to be reviewed for "reasonableness" at either the state or the federal level. HHS established a federal premium rate review process that generally applies to proposed premium rate increases equal to or exceeding a federally (or lower state) specified threshold. HHS's rate review process imposes additional public disclosure requirements as well as additional review on filings requesting premium rate increases equal to or exceeding this

“reasonableness” threshold. These combined state and federal review requirements may prevent, further delay or otherwise affect the Company’s ability to price for the risk it assumes, which could adversely affect its MBRs and results of operations, particularly during periods of increased utilization of medical services and/or medical cost trend or when such utilization and/or trend exceeds the Company’s projections.

The ACA also specifies minimum MLRs of 85% for large group Commercial products and 80% for individual and small group Commercial products. Because the ACA minimum MLRs are structured as “floors” for many of their requirements, states have the latitude to enact more stringent rules governing its various restrictions. For Commercial products, states have and may adopt higher minimum MLR requirements, use more stringent definitions of “medical loss ratio,” incorporate minimum MLR requirements into prospective premium rate filings, require prior approval of premium rates or impose other requirements related to minimum MLR. Minimum MLR requirements and similar actions further limit the level of margin the Company can

earn in its Insured Commercial business while leaving the Company exposed to medical costs that are higher than those reflected in its pricing. The Company also may be subject to significant fines, penalties, premium refunds and litigation if it fails to comply with minimum MLR laws and regulations.

In addition, the Company requested significant increases in its premium rates in its Commercial small group Health Care Benefits business for 2019 and expects to continue to request significant increases in those rates for 2020 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and significant assessments, fees and taxes imposed by the federal and state governments, including the ACA. The Company's rates also must be adequate to reflect adverse selection in its products, particularly in small group Commercial products, which the Company expects to continue and potentially worsen in 2019. These significant rate increases heighten the risks of adverse public and regulatory action and adverse selection and the likelihood that the Company's requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

Many of the laws and regulations governing the Company's pricing and underwriting practices also limit the differentials in premium rates insurers and other carriers may charge between new and renewal business, and/or between groups based on differing characteristics. They may also require that carriers disclose to customers the basis on which the carrier establishes new business and renewal premium rates and limit the ability of a carrier to terminate customers' coverage. In addition, HHS' rules on rates impose additional public disclosure requirements on any rate filings that exceed the "reasonableness" threshold and require additional review of those rates.

Medicaid Regulation - The Company is seeking to substantially grow its Medicaid, dual eligible and dual eligible special needs plan businesses over the next several years. As a result, the Company also is increasing its exposure to changes in government policy with respect to and/or regulation of the various Medicaid, dual eligible and dual eligible special needs plan programs in which the Company participates, including changes in the amounts payable to the Company under those programs.

Since 2017, Managed Medicaid products, including those the Company offers, are subject to a minimum MLR of 85%. A Medicaid managed care quality rating system and provider network adequacy requirements also apply to Medicaid products. Because the minimum MLR is structured as a "floor", states have the latitude to enact more stringent rules governing these various restrictions. For Managed Medicaid products, states may adopt higher minimum MLR requirements, use more stringent definitions of "medical loss ratio" or impose other requirements related to minimum MLR. Minimum MLR requirements and similar actions further limit the level of margin the Company can earn in its Insured Medicaid products while leaving the Company exposed to medical costs that are higher than those reflected in its pricing. The Company also may be subject to significant fines, penalties, premium refunds and litigation if it fails to comply with minimum MLR laws and regulations.

The impact of Medicaid expansion under the ACA is uncertain. The future of the ACA is uncertain, and states may opt out of the elements of the ACA requiring expansion of Medicaid coverage without losing their current federal Medicaid funding. To date, a number of states and the District of Columbia have expanded Medicaid coverage to the higher eligibility levels contemplated by the ACA. In addition, the election of new governors and/or state legislatures may impact states' previous decisions regarding Medicaid expansion. Proposals for substantial changes to federal funding of state Medicaid programs are likely to be considered in 2019 and beyond, including the possibility of converting federal Medicaid support to block grants and per capita caps on federal funding. Uncertainty regarding federal funding is causing and will continue to cause states to re-evaluate their Medicaid expansions and consider new assessments, fees and/or taxes on health plans. That re-evaluation may adversely affect Medicaid payment rates, the Company's revenues and its Medicaid membership in those states.

The economic aspects of the Medicaid, dual eligible and dual eligible special needs plan business vary from state to state and are subject to frequent change. Medicaid premiums are paid by each state and differ from state to state. The federal government and certain states also are considering proposals and legislation for Medicaid and dual eligible program reforms or redesigns, including restrictions on the collection of manufacturer's rebates on pharmaceuticals by Medicaid MCOs and their contracted PBMs, further program, population and/or geographic expansions of risk-based managed care, increasing beneficiary cost-sharing or payment levels, and changes to benefits, reimbursement, eligibility criteria, provider network adequacy requirements (including requiring the inclusion of specified high cost providers in the Company's networks) and program structure. In some states, current Medicaid and dual eligible funding and premium revenue may not be adequate for the Company to continue program participation. The Company's Medicaid and dual eligible contracts with states (or sponsors of Medicaid managed care plans) are

subject to cancellation by the state (or the sponsors of the managed care plans) after a short notice period without cause (for example, when a state discontinues a managed care program) or in the event of insufficient state funding.

The Company’s Medicaid, dual eligible and dual eligible special needs plan products also are heavily regulated by CMS and state Medicaid agencies, which have the right to audit the Company’s performance to determine compliance with CMS

contracts and regulations. The Company's Medicaid products, dual eligible products and CHIP contracts also are subject to complex federal and state regulations and oversight by state Medicaid agencies regarding the services provided to Medicaid enrollees, payment for those services, network requirements (including mandatory inclusion of specified high-cost providers), and other aspects of these programs, and by external review organizations which audit Medicaid plans on behalf of the state Medicaid agencies. The laws, regulations and contractual requirements applicable to the Company and other participants in Medicaid and dual eligible programs, including requirements that the Company submit encounter data to the applicable state agency, are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and its Medicaid and dual eligible program compliance efforts will continue to require significant resources. CMS and/or state Medicaid agencies may fine the Company, withhold payments to the Company, seek premium and other refunds, terminate the Company's existing contracts, elect not to award the Company new contracts or not to renew the Company's existing contracts, prohibit the Company from continuing to market and/or enroll members in or refuse to automatically assign members to one or more of the Company's Medicaid or dual eligible products, exclude the Company from participating in one or more Medicaid or dual eligible programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS or state regulations or contractual requirements.

The Company cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid program, nor can it predict the impact those changes will have on its business operations or results of operations, but the effects could be materially adverse.

State Workers' Compensation Laws - The Company's workers' compensation business includes the comparison of medical claims data against the applicable state's fee schedule pricing, including applicable regulations and clinical guidelines. State fee schedules, which typically represent the maximum reimbursement for medical services provided to the injured worker, differ by state and change as state laws and regulations are passed and/or amended. The Company's workers' compensation business also includes PBM and care management services, both of which are regulated at the state level. The Company's workers' compensation customers include insurance carriers and TPAs who also are regulated at the state level. The laws and regulations applicable to the Company and other participants in the workers' compensation business are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and its workers' compensation compliance efforts will continue to require significant resources. The Company may be subject to significant fines, penalties and litigation if it fails to comply with those laws and regulations.

Federal and State Reporting - The Company is subject to extensive financial and business reporting requirements, including penalties for inaccuracies and/or omissions, at both the federal and state level. The Company's ability to comply with certain of these requirements depends on receipt of information from third parties that may not be readily available or reliably provided in all instances. The Company is and will continue to be required to modify its information systems, dedicate significant resources and incur significant expenses to comply with these requirements. However, the Company cannot eliminate the risks of unavailability of or errors in its reports.

Product Design and Administration and Sales Practices - State and/or federal regulatory scrutiny of health care benefit product design and administration and marketing and advertising practices, including the filing of insurance policy forms, the adequacy of provider networks, the accuracy of provider directories, and the adequacy of disclosure regarding products and their administration, is increasing as are the penalties being imposed for inappropriate practices. Medicare, Medicaid and dual eligible products and products offering more limited benefits in particular continue to attract increased regulatory scrutiny.

Guaranty Fund Assessments/Solvency Protection - Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company's assessments generally are based on a formula relating to its health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer governed health plans established under the ACA. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

Available Information

CVS Health Corporation was incorporated in Delaware in 1996. The corporate office is located at One CVS Drive, Woonsocket, Rhode Island 02895, telephone (401) 765-1500. The Company’s common stock is listed on the New York Stock

Exchange under the trading symbol “CVS.” General information about CVS Health is available through the Company’s website at *http://www.cvshealth.com*. The Company’s financial press releases and filings with the SEC are available free of charge within the Investors section of the Company’s website at *http://www.cvshealth.com/investors*. In addition, the SEC maintains an internet site that contains reports, proxy and information statements and other information regarding issuers, such as the Company, that file electronically with the SEC. The address of that website is *http://www.sec.gov.* The information on or linked to the Company’s website is neither a part of nor incorporated by reference in this Annual Report on Form 10-K or any of the Company’s other SEC filings.

In accordance with guidance provided by the SEC regarding use by a company of its websites and social media channels as a means to disclose material information to investors and to comply with its disclosure obligations under Regulation FD, CVS Health Corporation (the “Registrant”) hereby notifies investors, the media and other interested parties that it intends to continue to use its media and investor relations website (http://investors.cvshealth.com/) and its Twitter feed (@CVSHealthIR) to publish important information about the Registrant, including information that may be deemed material to investors. The list of social media channels that the Registrant uses may be updated on its media and investor relations website from time to time. The Registrant encourages investors, the media, and other interested parties to review the information the Registrant posts on its website and social media channels as described above, in addition to information announced by the Registrant through its SEC filings, press releases and public conference calls and webcasts.

Item 1A. Risk Factors

You should carefully consider each of the following risks and uncertainties and all of the other information set forth in this Annual Report on Form 10-K. These risks and uncertainties and other factors may affect forward-looking statements, including those we make in this Annual Report on Form 10-K or elsewhere, such as in news releases or investor or analyst calls, meetings or presentations. The risks and uncertainties described below are not the only ones we face. There can be no assurance that we have identified all the risks that affect us. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial also may adversely affect our businesses. Any of these risks or uncertainties could cause our actual results to differ materially from our expectations and the expected results discussed in our forward-looking statements. You should not consider past results to be an indication of future performance.

If any of the following risks or uncertainties develops into actual events or if the circumstances described in the risks or uncertainties occur or continue to occur, these events or circumstances could have a material adverse effect on our businesses, results of operations, cash flows and/or financial condition. In that case, our stock price could decline materially, among other effects on us. You should read the following section in conjunction with “Management’s Discussion and Analysis of Financial Condition and Results of Operations” (which includes our “Cautionary Statement Concerning Forward-Looking Statements” at the end of such section) in the Annual Report, which is incorporated by reference herein, and our consolidated financial statements and the related notes.

Overarching Risks

Risks to our brand and reputation, the Aetna Acquisition, data governance risks, effectiveness of our talent management and alignment of talent to our business needs, and potential changes in public policy, laws and regulations present overarching risks to our enterprise in 2019 and beyond.

We expect to face significant business challenges and uncertainties in 2019. Risks to our brand and reputation, the Aetna Acquisition, data governance risks, effectiveness of our talent management and alignment of talent to our business needs, and potential changes in public policy, laws and regulations present overarching risks to our enterprise in 2019 and beyond. There can be no assurance regarding our ability to avoid harm to our brand and reputation, our ability to manage the risks inherent in the Aetna Acquisition or our data governance risks, our ability to manage and align our talent to our business needs or our ability to manage the risks presented by changes in public policy, laws or regulations. In addition, there can be no assurance that the Aetna Acquisition, United States government fiscal policy, changes to the United States health care system (including changes to the ACA, to drug reimbursement and/or drug pricing laws and regulations and/or to laws and regulations governing PBMs’ interactions with government funded health care programs) or other unanticipated risks will not require us to revise the ways in which we conduct business, put us at risk of loss of business or materially adversely affect our businesses, cash flows, financial condition or results of operations.

Our brand and reputation are two of our most important assets; negative public perception of the industries in which we operate, or of our industries' or our practices, can adversely affect our businesses, results of operations, cash flows and prospects.

Reputational risk is inherent in many of the risks we face. The industries in which we operate regularly are negatively perceived by the public and subject to negative publicity, including as a result of adverse media coverage, litigation against us and other industry participants, the ongoing public debates over drug pricing, government involvement in drug pricing and purchasing, PBMs and the future of the ACA, governmental hearings and/or investigations and actual or perceived shortfalls regarding our industries' or our own products and/or business practices (including PBM operations, drug pricing, insurance coverage determinations and social media and other media relations activities). This risk may be increased as the federal government continues to consider increased involvement in drug reimbursement, pricing and/or purchasing and changes to the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, and as states seek to maintain, replace or repeal elements of the ACA such as Public Exchanges and Medicaid expansion within increasingly challenging budget constraints. This risk also may be increased as we continue to offer products and services that make greater use of data and as our business model becomes more focused on delivering health care to consumers. Significant reductions or interruptions in funding for government health programs we serve also may lead us to reduce our exposure to these programs, which could adversely affect our brand and reputation.

Negative public perception and/or publicity of our industries in general, or of us or our key vendors, brokers or product distribution networks in particular, can further increase our costs of doing business and adversely affect our results of operations and our stock price by:

- Adversely affecting our brand and reputation;
- Adversely affecting our ability to market and sell our products and/or services and/or retain our existing customers and members;
- Requiring us to change our products and/or services;
- Reducing or restricting the compensation we can receive for our products and/or services; and/or
- Increasing or significantly changing the regulatory and legislative requirements with which we must comply.

Data governance failures can adversely affect our reputation, businesses and prospects. Our use and disclosure of members', customers' and other constituents' sensitive information is subject to complex regulations at multiple levels. We would be adversely affected if we or our business associates or other vendors fail to adequately protect members', customers' or other constituents' sensitive information.

Our information systems are critical to the operation of our businesses. We collect, process, maintain, retain, evaluate, utilize and distribute large amounts of personal health and financial information and other confidential and sensitive data about our customers, members and other constituents in the ordinary course of our businesses. Some of our information systems rely upon third party systems to accomplish these tasks. The use and disclosure of such information is regulated at the federal, state and international levels, and these laws, rules and regulations are subject to change and increased enforcement activity, such as the EU's GDPR which began to apply across the EU during 2018 and the audit program implemented by HHS under HIPAA. In some cases, such laws, rules and regulations also apply to our vendors and/or may hold us liable for any violations by our vendors. International laws, rules and regulations governing the use and disclosure of such information are generally more stringent than in the United States, and they vary from jurisdiction to jurisdiction. Noncompliance with any privacy or security laws or regulations, or any security breach, cyber-attack or cybersecurity breach, and any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, sensitive or confidential member, customer or other constituent information, whether by us, by one of our vendors or by another third party, could require us to expend significant resources to remediate any damage, interrupt our operations and damage our brand and reputation, and could also result in investigations, regulatory enforcement actions, material fines and penalties, loss of customers, litigation or other actions which could have a material adverse effect on our brand, reputation, businesses, results of operations and cash flows.

Our businesses depend on our customers' and members' willingness to entrust us with their health related and other sensitive personal information. Events that adversely affect that trust, including inadequate disclosure to our members or customers of our uses of their information, failing to keep our information technology systems and our members', customers' and other constituents' sensitive information secure from significant attack, theft, damage, loss or unauthorized disclosure or access, whether as a result of our action or inaction or that of our business associates, vendors or other third parties, could adversely affect our brand and reputation, membership and results of operations and also can and/or has exposed us to mandatory disclosure to the media, litigation (including class action litigation), governmental investigations and enforcement proceedings,

material fines, penalties and/or remediation costs, and compensatory, special, punitive and statutory damages, consent orders, adverse actions against our licenses to do business and/or injunctive relief, any of which could adversely affect our businesses, cash flows, results of operations or financial condition. Large scale data breaches at other entities increase the challenge we and our vendors face in maintaining the security of our information technology systems and of our customers', members' and other constituents' sensitive information. There can be no assurance that additional such failures will not occur, or if any do occur, that we will detect them or that they can be sufficiently remediated.

We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success, and our failure to do so could adversely affect our future performance.

Our ability to attract and retain qualified and experienced employees is essential to meet our current and future goals and objectives. There is no guarantee we will be able to attract and retain such employees or that competition among potential employers will not result in increased salaries or other benefits. If we are unable to retain existing employees or attract additional employees, or we experience an unexpected loss of leadership, we could experience a material adverse effect on our businesses and results of operations.

In addition, our failure to adequately plan for succession of senior management and other key management roles or the failure of key employees to successfully transition into new roles could have a material adverse effect on our businesses and results of operations. The succession plans we have in place and our employment arrangements with certain key executives do not guarantee the services of these executives will continue to be available to us.

We are subject to potential changes in public policy, laws and regulations, including reform of the United States health care system, that can adversely affect the markets for our products and services and our businesses, operations, results of operations, cash flows and prospects.

The political environment in which we operate remains uncertain. It is reasonably possible that our business operations and results of operations could be materially adversely affected by legislative, regulatory and public policy changes at the federal or state level, increased government involvement in drug reimbursement, pricing and/or purchasing, increased regulation of PBMs, changes to Medicare, Medicaid or the regulatory environment for health care benefits, including the ACA, changes to drug reimbursement and/or pricing laws and regulations, changes to the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, changes to immigration policies and/or many other public policy initiatives. For example, in January 2019, HHS proposed regulations that would exclude from the current safe harbor under the federal anti-kickback statute manufacturer's rebates on prescription drugs paid to PBMs, PDPs and Managed Medicaid organizations in connection with federally funded health care programs. It is not possible to predict whether or when any such changes will occur or what form any such changes may take (including through the use of United States Presidential Executive Orders). Other significant changes to health care system legislation or regulation as well as changes with respect to tax and trade policies, tariffs and other government regulations affecting trade between the United States and other countries are also possible and could adversely affect us. If we fail to respond adequately to such changes, including by implementing strategic and operational initiatives, or do not do so as effectively as our competitors, our businesses, operations and results of operations may be materially adversely affected.

In addition to efforts to amend, repeal or replace the ACA and related regulations, we expect the federal and state governments to continue to enact and seriously consider many broad-based legislative and regulatory proposals that will or could materially impact various aspects of the health care and related benefits system and our businesses. Potential modification to the ACA, including changes in enforcement and/or funding that further destabilize the Public Exchanges, as well as significant changes to Medicaid funding could impact the number of Americans with health insurance and, consequently, prescription drug coverage. Further changes to federal health care laws, including the ACA, drug reimbursement and pricing laws and/or laws governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, are probable. We cannot predict the effect, if any, that new health care legislation, future changes to the ACA or the implementation or failure to implement the outstanding provisions of ACA, may have on our retail pharmacy, LTC pharmacy, specialty pharmacy, pharmacy services and/or Health Care Benefits operations and/or results of operations. The federal and many state governments also are considering changes in the interpretation, enforcement and/or application of existing programs, laws and regulations, including changes to payments under and funding of Medicare and Medicaid programs.

In addition, much of the branded and generic drug product that we sell in our retail, mail and specialty pharmacies, and much of the other merchandise we sell, is manufactured in whole or in substantial part outside of the United States. In most cases, the products or merchandise are imported by others and sold to us. As a result, significant changes in tax or trade policies, tariffs or trade relations between the United States and other countries, such as the imposition of unilateral tariffs on imported products, could result in significant increases in our costs, restrict our access to suppliers, depress economic activity, and have a material

adverse effect on our businesses, cash flows and results of operations. In addition, other countries may change their business and trade policies and such changes, as well as any negative sentiments towards the United States in response to increased import tariffs and other changes in United States trade regulations, could adversely affect our businesses.

We cannot predict the enactment or content of new legislation and regulations or changes to existing laws or regulations or their enforcement, interpretation or application, or the effect they will have on our business operations or results of operations, which could be materially adverse. Even if we could predict such matters, it is not possible to eliminate the adverse impact of public policy changes that would fundamentally change the dynamics of one or more of the industries in which we operate. Examples of such change include: the federal or one or more state governments fundamentally restructuring or reducing the funding available for Medicare, Medicaid, dual eligible or dual eligible special needs plan programs, increasing its involvement in drug reimbursement, pricing and/or purchasing, changing the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, changing the tax treatment of health or related benefits, or repealing or otherwise significantly altering the ACA. The likelihood of adverse changes remains high due to state and federal budgetary pressures, and our businesses and results of operations could be materially and adversely affected by such changes, even if we correctly predict their occurrence. For more information on these matters, see "Government Regulation" included in Item 1 of this Annual Report on Form 10-K.

Our enterprise strategy may not be an effective response to the changing dynamics in the industries in which we operate, or we may not be able to implement our strategy and related strategic projects.

Our strategy includes effectively investing our capital and human resources in appropriate strategic projects, current operations and acquisitions to transform our businesses in response to the changing dynamics in the industries in which we operate. Our strategic projects include, among other things: integrating the Aetna Acquisition; significant investments in human and technology resources to expand our consumer-oriented products and services; optimizing our business platforms; managing certain significant technology projects; further improving relations with manufacturers, suppliers and health care providers; negotiating contract changes with customers, manufacturers, suppliers and health care providers and implementing other business process improvements. Implementing our strategic initiatives will require significant investments of capital and human resources. Among other things, we will need to simultaneously acquire and develop new personnel, products and systems to serve existing and new customers with existing and new products and to enhance our existing customer service, information technology, control and compliance processes and systems. The future performance of our businesses will depend in large part on our ability to design and implement our strategic initiatives, some of which will occur over several years. If these initiatives do not achieve their objectives, our results of operations could be adversely affected.

Our enterprise strategy may not be an effective response to the changing dynamics in the industries in which we operate, and we may fail to recognize and position ourselves to capitalize upon market opportunities. We may not have sufficient advance notice and resources to develop and effectively implement an alternative strategy. If our existing competitors and/or new entrants (whether vertical, horizontal or online/digital/e-commerce) into one or more of our businesses create new disruptive business models and/or develop new offerings that customers, members and/or health care providers prefer to our offerings, we may lose customers, members and/or providers, and our results of operations, cash flows and/or prospects may be adversely affected. In addition, our results of operations, cash flows and/or prospects may be adversely affected by consolidation among the participants in the industries in which we operate and/or our customer base. Our businesses and results of operations could be materially and adversely affected by such changes, even if we correctly predict their occurrence.

Risks Related to Our Businesses

Efforts to reduce reimbursement levels and alter health care financing practices could adversely affect our businesses.

The continued efforts of HMOs, MCOs, PBMs, government entities, and other third party payors to reduce prescription drug costs and pharmacy reimbursement rates, as well as litigation and other legal proceedings relating to how drugs are priced, may adversely affect our profitability. In particular, increased utilization of generic drugs (which normally yield a higher gross profit rate than equivalent brand named drugs) has resulted in pressure to decrease reimbursement payments to retail, specialty, LTC and mail order pharmacies for generic drugs, causing a reduction in our margins on sales of generic drugs. Historically, the effect of this trend on generic profitability has

been mitigated by the introduction of new multi-source generic drugs as well as inflation on brand name drugs and by our efforts to negotiate reduced acquisition costs of generic drugs with manufacturers. However, in recent years, there has been significant consolidation within the generic manufacturing industry and in 2019 we expect fewer new multi-source generic drugs to be introduced and lower brand name drug inflation than in recent prior years, and it is possible that these and other external factors may enhance the ability of manufacturers to sustain or increase pricing of generic drugs and diminish our ability to negotiate reduced acquisition costs. Any inability to offset increased brand name or

generic prescription drug costs or to modify our activities to lessen the financial impact of such increased costs could have a significant adverse effect on our results of operations.

In addition, during the past several years, the United States health care industry has been subject to an increase in governmental regulation and audits at both the federal and state levels. Efforts to control health care costs, including prescription drug costs, are continuing at the federal and state government levels. Changing political, economic and regulatory influences may significantly affect health care financing and reimbursement practices. For example, we anticipate that federal and state governments will continue to review and assess alternative health care delivery systems, payment methodologies and operational requirements for health care providers, including LTC facilities and pharmacies, and participants in government funded health care programs. A change in the composition of pharmacy prescription volume toward programs offering lower reimbursement rates could adversely affect our profitability. Any action taken to repeal or replace all or significant parts of ACA also could adversely affect our profitability, though it is unclear at this time what the full effects of any such changes would be.

The ACA made several significant changes to Medicaid rebates and to reimbursement rates. One of these changes was to revise the definition of the Average Manufacturer Price, a pricing element common to most payment formulas, and the reimbursement formula for generic drugs. This change has adversely affected the reimbursements we receive when we dispense prescription drugs to Medicaid recipients. In addition, the ACA made other changes that affect the coverage and plan designs that are or will be provided by many of our health plan clients, including the requirement for health insurers to meet a minimum MLR to avoid having to pay rebates to enrollees. These ACA changes may not affect our businesses directly, but they could indirectly impact our services, business practices and/or results of operations.

Gross margins in the industries in which we operate may decline.

The PBM industry has been experiencing margin pressure as a result of competitive pressures and increased client demands for lower prices, increased revenue sharing, enhanced service offerings and/or higher service levels. In that regard, we maintain contractual relationships with generic drug manufacturers and brand name drug manufacturers that provide for purchase discounts and/or rebates on drugs dispensed by pharmacies in our retail network and by our specialty and mail order pharmacies (all or a portion of which may be passed on to clients). Manufacturer's rebates often depend on a PBM's ability to meet contractual market share or other requirements, including in some cases the placement of a manufacturer's products on the PBM's formularies. If we lose our relationship with one or more drug manufacturers, or if the discounts or rebates provided by drug manufacturers decline, our businesses and results of operations could be adversely affected. Further, competitive pressures in the PBM industry have resulted in our clients sharing in a larger portion of rebates and/or discounts received from drug manufacturers. Marketplace dynamics and regulatory changes also have impacted our ability to offer plan sponsors pricing that includes the use of retail "differential" or "spread", which could adversely affect our future profitability, and we expect these trends to continue. Further, changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to additional regulation of PBMs, drug pricing or purchasing, patent term extensions, purchase discount and/or rebate arrangements with drug manufacturers, or additional regulation of PBMs, formulary management or other PBM services could also reduce the discounts or rebates we receive. In addition, changes in federal or state laws or regulations or the adoption of new laws or regulations relating to claims processing and billing, including our ability to use MAC lists and collect transmission fees, could adversely affect our profitability.

Our retail pharmacy, specialty pharmacy and LTC pharmacy operations also have been affected by the margin pressures described above, including client demands for lower prices, generic pricing and network reimbursement pressure. In addition, as competition increases in the geographies in which we operate, including competition from new entrants, a significant increase in general pricing pressures could occur, and this could require us to reevaluate our pricing structures to remain competitive. A shift in the mix of our pharmacy prescription volume towards programs offering lower reimbursement rates could adversely affect our margins, including the ongoing shift in pharmacy mix towards 90-day prescriptions at retail and the ongoing shift in pharmacy mix towards Medicare Part D prescriptions. Finally, the margins of our LTC business are further affected by the increased efforts of health care payors to negotiate reduced or capitated pricing arrangements. These actions could also adversely affect the margins of our LTC business.

Our results of operations are affected by the health of the economy in general and in the geographies we serve.

Our businesses are affected by the United States economy and consumer confidence in general and in the geographies we serve, including various economic factors, inflation and changes in consumer purchasing power, preferences and/or spending patterns. It is possible that an unfavorable, uncertain or volatile economic environment will cause a decline in drug utilization, an increase in health care utilization and dampen demand for PBM services as well as consumer demand for products sold in our retail stores. Further, economic conditions including interest rate fluctuations, changes in capital market conditions and

regulatory changes may affect our ability to obtain necessary financing on acceptable terms, our ability to secure suitable store locations under acceptable terms and our ability to execute sale-leaseback transactions under acceptable terms. Adverse changes in the United States economy, consumer confidence and economic conditions could have an adverse effect on our businesses and financial results. This adverse effect could be further exacerbated by the increasing prevalence of high deductible health plans and health plan designs favoring co-insurance over co-payments as members and other consumers may decide to postpone, or not to seek, medical treatment which may lead them to incur more expensive medical treatment in the future and/or decrease our prescription volumes.

In addition, our Health Care Benefits membership remains concentrated in certain geographic areas in the United States and in certain industries. Unfavorable changes in health care or other benefit costs or reimbursement rates or increased competition in those geographic areas where our membership is concentrated could therefore have a disproportionately adverse effect on our Health Care Benefits results of operations. Our Health Care Benefits membership has been and may continue to be affected by workforce reductions by our customers due to adverse and/or uncertain general economic conditions, especially in the United States geographies and industries where our membership is concentrated. As a result, we may not be able to profitably grow and diversify our Health Care Benefits membership geographically, by product type or by customer industry, and our revenue and results of operations may be disproportionately affected by adverse changes affecting our customers.

We operate in a highly competitive business environment. Competitive and economic pressures may limit our ability to increase pricing to reflect higher costs or may force us to accept lower margins. If customers elect to self-insure, reduce benefits or adversely renegotiate or amend their agreements with us, our revenues and results of operations will be adversely affected. We may not be able to obtain appropriate pricing on new or renewal business.

Each of our businesses currently operates in a highly competitive and evolving business environment. We must compete successfully with existing competitors and new entrants, including strategic alliances and online, digital and e-commerce companies.

The competitive success of our retail pharmacy business, as well as our specialty pharmacy operations with third-party payors, is dependent on our ability to establish and maintain contractual relationships with PBMs and other payors on acceptable terms in an environment where some PBM clients are considering adopting narrow or restricted retail pharmacy networks. As a pharmacy retail business, we compete with other drugstore chains, supermarkets, online and other discount retailers, independent pharmacies, membership clubs, convenience stores and mass merchants, some of which are aggressively expanding into markets we serve. We also face competition from other retail health care clinics, as well as other mail order pharmacies and PBMs. Disruptive innovation by existing or new competitors could alter the competitive landscape in the future and require us to accurately identify and assess such changes and make timely and effective changes to our strategies and business model to compete effectively. Competition may also come from other sources in the future. Changes in market dynamics or the actions of competitors or manufacturers, including industry consolidation, the emergence of new competitors and strategic alliances, and decisions to exclude us from new narrow or restricted retail pharmacy networks, could materially and adversely affect our businesses, results of operations, cash flows and prospects.

We also could be adversely affected if we fail to identify or effectively respond to changes in market dynamics. For example, specialty pharmacy represents a significant and growing proportion of prescription drug spending in the United States, a significant portion of which is dispensed outside of traditional retail pharmacies. Because our specialty pharmacy operations focus on complex and high-cost medications that serve a relatively limited universe of patients, the future growth of this business depends to a significant extent upon expanding our ability to access key drugs and successfully penetrate key treatment categories.

The competitive success of our LTC pharmacy operations is dependent upon our ability to compete in each geographic region where we have operations. In the geographic regions we serve, we compete with PharMerica, our largest LTC pharmacy competitor, as well as with numerous local and regional institutional pharmacies, pharmacies owned by long-term care facilities and local retail pharmacies. Our LTC pharmacy customers consist of skilled nursing facilities, assisted living facilities, independent living communities, hospitals, correctional facilities, and other health care service providers. One of our growth opportunities is to increase our penetration rate in the assisted living segment, where residents can choose which pharmacy will provide them with prescription drugs. The ability of a resident of an assisted living facility to select the pharmacy that supplies him or her with prescription drugs could

adversely affect our business, financial condition and results of operations because there can be no assurance that such resident will select us.

The competitive success of our pharmacy services business is impacted by its ability to establish and maintain contractual relationships with network pharmacies in an environment where some PBM clients are considering adopting narrow or restricted retail pharmacy networks. Competitors in the PBM industry (e.g., the Express Scripts business of Cigna Corporation,

OptumRx, Prime Therapeutics, MedImpact and Humana), include large, national PBM companies, PBMs owned by large national health plans and smaller standalone PBMs. Competition also may come from other sources in the future. In addition, changes in the overall composition of our pharmacy networks, or reduced pharmacy access under our networks, could adversely affect our claims volume and/or our competitiveness generally.

Customer contracts in our Health Care Benefits segment are generally for a period of one year, and our customers have considerable flexibility in moving between us and our competitors. One of the key factors on which we compete for customers, especially in uncertain economic environments, is overall cost. We are therefore under pressure to contain premium price increases despite being faced with increasing health care and other benefit costs and increasing operating costs. If we are unable to increase our prices to reflect increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose members to competitors with more favorable pricing, adversely affecting our revenues and results of operations. In response to rising prices, our customers may elect to self-insure or to reduce benefits in order to limit increases in their benefit costs. Alternatively, our customers may purchase different types of products from us that are less profitable. Such elections may result in reduced membership in our more profitable Insured products and/or lower premiums for our Insured products, which may adversely affect our revenues and results of operations, although such elections also may reduce our health care and other benefit costs. In addition, our Medicare, Medicaid and CHIP products are subject to termination without cause, periodic re-bid, rate adjustment and program redesign, as customers seek to contain their benefit costs, particularly in an uncertain economy. These actions may adversely affect our membership, revenues and results of operations

Competitors in each of our businesses may offer services and pricing terms that we may not be willing or able to offer. For example, strong competition in the PBM marketplace has generated greater client demand for lower pricing, increased revenue sharing and enhanced product and service offerings. Unless we can demonstrate enhanced value to our clients through innovative product and service offerings, particularly in a rapidly changing health care industry, we may be unable to remain competitive.

We may lose clients and/or fail to win new business. If we fail to compete effectively in the geographies and product areas in which we operate, including maintaining or increasing membership in our Health Care Benefits segment, our results of operations, financial condition and cash flows could be materially and adversely affected.

Our PBM business generates revenues primarily by contracting with clients to provide prescription drugs and related health care services to plan members. PBM client contracts often have terms of approximately three years in duration, so approximately one third of a PBM's client base typically is subject to renewal each year. In some cases, however, PBM clients may negotiate a shorter or longer contract term or may require early or periodic renegotiation of pricing prior to expiration of a contract. Our clients are generally well informed and organized, can move between our competitors and often seek competing bids prior to expiration of their contracts. In addition, the reputational impact of a service-related incident could adversely affect our businesses. These factors, together with the impact of competitive pressures, could make it difficult for us to attract new clients, retain existing clients and cross-sell additional products and/or services. Further, the PBM industry has been affected by consolidation activity that may continue in the future. If one or more of our PBM clients is acquired by an entity that is not also our client, we may be unable to retain all or a portion of the acquired client's business. These circumstances, either individually or in the aggregate, could result in an adverse effect on our businesses and financial results. Therefore, we continually face challenges in competing for new PBM business and retaining or renewing our existing PBM business. With respect to our LTC pharmacy business, reimbursement from skilled nursing facilities for prescriptions we dispense is determined pursuant to our agreements with those skilled nursing facilities. The termination of these agreements generally terminates our ability to provide services to any of the residents of that facility, resulting in the loss of revenue from any source for those residents. There can be no assurance that we will be able to win new business or secure renewal business on terms as favorable to us as the present terms.

Additionally, with respect to our retail and LTC pharmacy businesses, reimbursement under Medicare Part D, as well as reimbursement from certain private third-party payors, is determined pursuant to agreements that we negotiate with those payors or their PBM representatives. The loss of those agreements, or a material change in the terms of those agreements, could adversely affect our results of operations and cash flows. In addition, restricted networks that exclude our retail or specialty pharmacies adversely affect those businesses.

The health care and related benefits industry is highly competitive, primarily due to a large number of for-profit and not-for-profit competitors, our competitors' marketing and pricing, and a proliferation of competing products,

including new products that are continually being introduced into the marketplace. Our Health Care Benefits segment faces significant competition in all of the geographies and product areas in which it operates. New entrants into the marketplace, as well as consolidation within the industry, have contributed to and are expected to intensify the competitive environment. In addition, the rapid pace of change as the industry evolves towards a consumer-focused retail marketplace, including Insurance Exchanges, and the

increased use of technology to interact with members, providers and customers, increase the risks we currently face from new entrants and disruptive actions by existing competitors compared to prior periods.

Our Health Care Benefits segment competes on the basis of many factors, including perceived overall quality, quality of service, comprehensiveness of coverage, cost (including premium, provider discounts and member out-of-pocket costs), product design, financial stability and ratings, breadth and quality of provider networks, providers available in such networks, and quality of member support and care management programs. Our Health Care Benefits segment's competitors include, among others, UnitedHealth Group Incorporated, Anthem, Inc., Humana Inc., Cigna Corporation, WellCare Health Plans, Inc., Centene Corporation, Molina Healthcare, Inc., Kaiser Permanente, health system owned health plans and new entrants into the marketplace, and numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association. The Health Care Benefits segment's largest competitor in its Medicare products is Original Medicare. Additional competitors in this segment's businesses include other types of medical and dental provider organizations, various specialty service providers (including PBM services providers), health care consultants, financial services companies, integrated health care delivery organizations (networks of providers who also coordinate administrative services for and assume insurance risk of their members), TPAs, HIT companies and, for certain plans, programs sponsored by the federal or state governments. Emerging competitors include start up health care benefit plans, provider-owned health plans, new joint ventures (including for-profit and not-for-profit joint ventures among firms from multiple industries), technology firms, financial services firms that are distributing competing products on their proprietary Private Exchanges, consulting firms that are distributing competing products on their proprietary Private Exchanges, as well as non-traditional distributors such as retail companies. In particular geographies, competitors may have greater capabilities, resources or membership; a more established reputation; superior supplier or health care professional pricing and contract terms; better business relationships; or other factors that give such competitors a competitive advantage. The Health Care Benefits segment competes for sales on Insurance Exchanges and is developing and expanding its Consumer Health Products and Services product and service offerings, where we face additional risks from existing and new competitors (including our vendors) who have lower cost structures, greater experience marketing to consumers and/or who target the higher margin portions of our business. Among the Health Care Benefits segment's international and HIT competitors, many have longer operating histories, better brand recognition and greater market presence in many of the areas in which the segment is seeking to expand and more experience at rapidly innovating products.

There can be no assurance that the Aetna Acquisition will not adversely affect any of our segments' respective abilities to attract new clients or retain existing clients or our ability to cross-sell additional products and/or services within any segment or between segments. If we do not compete effectively in the geographies and product areas in which we operate, our businesses, results of operations, financial condition and cash flows could be materially and adversely affected.

We are exposed to risks relating to the solvency of our customers and of other insurers.

If our customers' operating and financial performance deteriorates, or they are unable to make scheduled payments or obtain adequate financing, our customers may not be able to pay timely, or may delay payment of, amounts owed to us. Any inability of our customers to pay us for our products and services may adversely affect our businesses, financial condition and results of operations. In addition, both state and federal government sponsored payers, as a result of budget deficits or reductions, may suspend payments or seek to reduce their healthcare expenditures resulting in our customers delaying payments to us or renegotiating their contracts with us. Any delay or reduction in payments by such government sponsored payers may adversely affect our businesses, financial condition and results of operations.

We are subject to assessments under guaranty fund laws for obligations of insolvent insurance companies (such as the discounted estimated liability expense of $231 million pretax for our estimated share of future assessments for Penn Treaty Network America Insurance Company and one of its subsidiaries that Aetna recorded in the first quarter of 2017), HMOs, ACA co-ops and other payors to policyholders and claimants.

We face risks relating to the market availability, pricing, suppliers and safety profiles of prescription drugs that we purchase and sell.

We dispense significant volumes of brand-name and generic drugs from our retail, LTC, specialty and mail order pharmacies and through our PBM's network of retail pharmacies. When increased safety risk profiles or

manufacturing or other supply issues of specific drugs or classes of drugs occur, or drugs become subject to greater restrictions as controlled substances, physicians may cease writing prescriptions for these drugs or the utilization of these drugs may be otherwise reduced.

Additionally, adverse publicity regarding drugs with higher safety risk profiles may result in reduced consumer demand for such drugs. On occasion, products are withdrawn by their manufacturers or transition to over-the-counter products, which can

result in lower prescription utilization. In addition, future FDA rulings could restrict the supply or increase the cost of products sold to our customers. Our results of operations and cash flows may decline as a result of such regulatory rulings or market changes.

Further, we acquire a substantial amount of our mail and specialty pharmacies' prescription drug supply from a limited number of suppliers. Our agreements with these suppliers are often short-term and easily cancelable by either party without cause. In addition, these agreements may limit our ability to provide services for competing drugs during the term of the agreement and may allow the supplier to distribute through channels other than us. Certain of these agreements also allow pricing and other terms to be adjusted periodically for changing market conditions or required service levels. A termination or modification to any of these relationships could have a material adverse effect on our businesses, financial condition and results of operations. Moreover, many products distributed by our specialty pharmacy business are manufactured with ingredients that are susceptible to supply shortages. In some cases, we depend upon a single source of supply. Any such supply shortages or loss of any such single source of supply could adversely affect our results of operations and cash flows.

In addition, our suppliers are independent entities subject to their own operational and financial risks that are outside our control. If our current suppliers were to stop selling prescription drugs to us or delay delivery, including as a result of supply shortages, supplier production disruptions, supplier quality issues, closing or bankruptcies of our suppliers, or for other reasons, we may be unable to procure alternatives from other suppliers in a timely and efficient manner and on acceptable terms, or at all.

A disruption in our business operations could occur as a result of contamination of drugs, a failure to maintain necessary shipment and storage conditions, errors in mail order processing, the unavailability of prescription drugs provided by suppliers, labor disruptions or other unanticipated disruptions at our mail order dispensing pharmacy facilities, specialty pharmacy facilities, call centers, data centers or corporate facilities, among other factors. Such disruption could reduce our ability to process and dispense prescriptions and provide products and services to our customers.

If any products we distribute are in limited supply for significant periods of time, our financial condition and results of operations could be materially and adversely affected.

We face risks related to the frequency and rate of the introduction and pricing of generic drugs and brand name prescription drug products.

The profitability of our Retail/LTC and Pharmacy Services segments is dependent upon the utilization of prescription drug products. Utilization trends are affected by, among other factors, the introduction of new and successful prescription drugs as well as lower-priced generic alternatives to existing brand name products because we generally earn higher gross margins on the sale of generic alternatives than on brand name equivalents. In addition, inflation in the price of brand name drugs can affect utilization, particularly given the increase in high deductible health plans. Accordingly, our businesses and results of operations could be adversely affected by a slowdown or delay in the number or magnitude of new and successful prescription drugs and/or generic alternatives, as well as inflation in the price of brand name drugs. For example, we project that the operating income of our Pharmacy Services and Retail/LTC segments may be reduced in 2019 compared to 2018 due in part to fewer new multi-source generic drugs being introduced and lower brand name drug price inflation in 2019 than 2018.

Possible changes in industry pricing benchmarks and drug pricing generally can adversely affect our PBM business.

It is possible that the pharmaceutical industry or regulators may evaluate and/or develop an alternative pricing reference to replace AWP or Wholesale Acquisition Cost ("WAC"), which are the pricing references used for many of our PBM and LTC client contracts, drug purchase agreements, retail network contracts, specialty payor agreements and other contracts with third party payors in connection with the reimbursement of drug payments. In addition, many state Medicaid fee-for-service programs ("FFS Medicaid") have established pharmacy network payments on the basis of Actual Acquisition Cost ("AAC"). The use of an AAC basis in FFS Medicaid could have an impact on reimbursement practices in other commercial and government products. Future changes to the use of AWP, WAC or to other published pricing benchmarks used to establish drug pricing, including changes in the basis for calculating reimbursement by federal and state health programs and/or other payors, could impact the reimbursement we receive from Medicare and Medicaid programs, the reimbursement we receive from our PBM clients and other payors and/or

our ability to negotiate rebates and/or discounts with drug manufacturers, wholesalers, PBMs and retail pharmacies. A failure or inability to fully offset any increased prices or costs or to modify our operations to mitigate the impact of such increases could have a material adverse effect on our results of operations. Additionally, any future changes in drug prices could be significantly different than our projections. The effect of these possible changes on our businesses cannot be predicted at this time.

Product liability, product recall or personal injury issues could damage our reputation.

The products that we sell could become subject to contamination, product tampering, mislabeling, recall or other damage. In addition, errors in the dispensing and packaging of drugs and consuming drugs in a manner that is not prescribed could lead to serious injury or death. Product liability or personal injury claims may be asserted against us with respect to any of the drugs or other products we sell or services we provide. For example, we are a defendant in litigation proceedings relating to opioids and the sale of products containing talc. Our businesses involve the provision of professional services, including by pharmacists, physician assistants, nurses and nurse practitioners, that exposes us to professional liability claims. Should a product or other liability issue arise, the coverage limits under our insurance programs and the indemnification amounts available to us may not be adequate to protect us against claims. We also may not be able to maintain our existing levels of insurance on acceptable terms in the future. Damage to our reputation in the event of a product liability or personal injury issue or judgment against us or a product recall could have a significant adverse effect on our businesses, financial condition and results of operations.

We face challenges in growing our Medicare Advantage and Medicare Part D membership.

We are seeking to substantially grow our Medicare Advantage and Medicare Part D membership, revenue and results of operations in 2019 and over the next several years, including by significantly expanding our Medicare Advantage service area. The organic expansion of our Medicare Advantage service area is subject to the ability of CMS to process our requests for service area expansions and our ability to build cost competitive provider networks in the expanded service areas that meet applicable network adequacy requirements. CMS' decisions on our requests for service area expansions also may be affected adversely by compliance issues that arise each year in our Medicare operations. If we are not successful in expanding our Medicare Advantage service area, we may not be able to achieve our Medicare Advantage growth goals.

We face challenges in growing our Medicaid membership, and expanding our Medicaid membership exposes us to additional risks.

We are seeking to substantially grow our Medicaid, dual eligible and dual eligible special needs plan membership over the next several years. In many instances, to acquire and retain our government customers' business, we must bid against our competitors in a highly competitive environment. Winning bids often are challenged successfully by unsuccessful bidders. Our ability to maintain and grow membership, revenues and results of operations in our Medicaid products is dependent on our remaining competitive on price, performance and preparing successful bids. In cases where a successful bid is challenged, we incur defense costs and may incur unreimbursed implementation and other costs to meet contractual deadlines even if we ultimately lose the challenge.

If we are successful in expanding our Medicaid membership, we may increase our exposure to states that face budgetary pressures, hospitals and other providers that face revenue challenges associated with uncompensated care and pressures on our operating margins driven by the projected rapid growth in the size of and cost of care for the Medicaid eligible population.

A change in our Health Care Benefits product mix may adversely affect our profit margins.

Our Insured Health Care Benefits products that involve greater potential risk generally tend to be more profitable than our ASC products. Historically, smaller employer groups have been more likely to purchase Insured Health Care Benefits products because such purchasers are generally unable or unwilling to bear greater liability for health care expenditures, although recently even relatively small employers have moved to ASC products. We also serve government-sponsored programs, including Medicare and Medicaid, that are subject to competitive bids and regulatory requirements and have lower profit margins than the Insured Commercial products in our Health Care Benefits segment. Although our Health Care Benefits membership is projected to continue to shift towards Government products in 2019, the profitability of each of those products differs and may be less than the profitability of an Insured Commercial product. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on our results of operations.

We may not be able to accurately forecast health care and other benefit costs, which could adversely affect our Health Care Benefits segment's results of operations. There can be no assurance that the future health care and other benefit costs of our Insured Health Care Benefits products will not exceed our projections.

Premiums for our Insured Health Care Benefits products, which comprised 87% of our Health Care Benefits revenues for 2018, are priced in advance based on our forecasts of health care and other benefit costs during a fixed premium period, which is generally one year. These forecasts are typically developed several months before the fixed premium period begins, are influenced by historical data (and recent historical data in particular), are dependent on our ability to anticipate and detect medical cost trends and changes in our members' behavior and healthcare utilization patterns and require a significant degree of

judgment. For example, our revenue on Medicare policies is based on bids submitted in June of the year before the contract year. Cost increases in excess of our projections cannot be recovered in the fixed premium period through higher premiums. As a result, our profits are particularly sensitive to the accuracy of our forecasts and our ability to anticipate and detect medical cost trends. Even relatively small differences between predicted and actual health care and other benefit costs as a percentage of premium revenues can result in significant adverse changes in our results of operations.

Our health care and other benefit costs can be affected by external events that we cannot forecast or anticipate and over which we have little or no control, such as emerging changes in the economy and/or public policy, additional government mandated benefits or other regulatory changes, changes in our members' behavior and healthcare utilization patterns, changes in health care practices, new technologies, increases in the cost of prescription drugs, influenza related health care costs (which may be substantial and were higher than Aetna projected in 2017-2018), direct-to-consumer marketing by drug manufacturers, clusters of high cost cases, epidemics, pandemics, terrorist attacks or other man-made disasters, natural disasters or other events that materially increase utilization of medical and/or other covered services, including prescription drugs, as well as changes in provider billing practices. Our health care and other benefit costs also can be affected by changes in our business mix, product designs, contracts with providers, medical management, underwriting, rating and/or claims processing methods and processes, and our medical management initiatives may not deliver the reduction in utilization and/or medical cost trend that we project.

It is particularly difficult to accurately anticipate, detect, price, forecast, manage and reserve for medical cost trends and utilization of medical and/or other covered services during and following periods when such utilization and/or trends are below recent historical levels, during periods of changing economic conditions and employment levels and for products with substantial membership growth and/or turnover. For example, as of December 31, 2018, we held a premium deficiency reserve of $16 million for the 2019 coverage year related to our Medicaid products. We expect utilization to increase in 2019 when compared to 2018.

If health care and other benefit costs are higher than the levels reflected in our pricing or if we are not able to obtain appropriate pricing on new or renewal business, our prices will not reflect the risk we assume, and our results of operations will be adversely affected. If health care and other benefit costs are lower than we predict, our prices may be higher than those of our competitors, which may cause us to lose Health Care Benefits membership.

A number of factors, many of which are beyond our control, contribute to rising health care and other benefit costs. If we are unable to satisfactorily manage our health care and other benefit costs, our Health Care Benefits segment's results of operations and competitiveness will be adversely affected.

A number of factors contribute to rising health care and other benefit costs, including previously uninsured members entering the health care system, changes in members' behavior and healthcare utilization patterns, turnover in our membership, additional government mandated benefits or other regulatory changes, changes in the health status of our members, the aging of the population and other changing demographic characteristics, advances in medical technology, increases in the number and cost of prescription drugs (including specialty pharmacy drugs), direct-to-consumer marketing by drug manufacturers, the increasing influence of social media on our members' utilization and other behavior, changes in health care practices and inflation. In addition, government-imposed limitations on Medicare and Medicaid reimbursements to health plans and providers have caused the private sector to bear a greater share of increasing health care and other benefits costs over time, and future amendments or repeal or replacement of the ACA that increase the uninsured population may exacerbate this problem. Other factors that affect our health care and other benefit costs include changes as a result of the ACA, changes to the ACA and other changes in the regulatory environment, the evolution toward a consumer driven business model, changes in health care practices, general economic conditions (such as inflation and employment levels), new technologies, influenza related health care costs (which may be substantial and were higher than Aetna projected in 2017-2018), clusters of high-cost cases, epidemics or pandemics, health care provider and member fraud, and numerous other factors that are or may be beyond our control.

Our Health Care Benefits segment's results of operations and competitiveness depend in large part on our ability to appropriately manage future health care and other benefit costs through underwriting criteria, product design, provider network configuration, negotiation of favorable provider contracts and medical management programs. Our medical cost management programs may not be successful and may have a smaller impact on health care and benefit costs than we expect. The factors described above may adversely affect our ability to predict and manage health care and other benefit costs, which can adversely affect our competitiveness and results of operations.

The reserves we hold for expected claims in our Insured Health Care Benefits products are based on estimates that involve an extensive degree of judgment and are inherently variable. Any reserve, including a premium deficiency reserve, may be

insufficient. If actual claims exceed our estimates, our results of operations could be materially adversely affected, and our ability to take timely corrective actions to limit future costs may be limited.

A large portion of health care claims are not submitted to us until after the end of the quarter in which services are rendered by providers to our members. Our reported health care costs payable for any particular period reflect our estimates of the ultimate cost of such claims as well as claims that have been reported to us but not yet paid. We also must estimate the amount of rebates payable under the ACA's, CMS's and OPM's minimum MLR rules and the amounts payable by us to, and receivable by us from, the United States federal government under the ACA's remaining premium stabilization program.

Our estimates of health care costs payable are based on a number of factors, including those derived from historical claim experience, but this estimation process also makes use of extensive judgment. Considerable variability is inherent in such estimates, and the accuracy of the estimates is highly sensitive to changes in medical claims submission and processing patterns and/or procedures, turnover and other changes in membership, changes in product mix, changes in the utilization of medical and/or other covered services, including prescription drugs, changes in medical cost trends, changes in our medical management practices and the introduction of new benefits and products. We estimate health care costs payable periodically, and any resulting adjustments, including premium deficiency reserves, are reflected in current-period results of operations within benefit costs. For example, as of December 31, 2018, we held a premium deficiency reserve of $16 million for the 2019 coverage year related to our Medicaid products. A worsening (or improvement) of health care cost trend rates or changes in claim payment patterns from those that we assumed in estimating health care costs payable as of December 31, 2018 would cause these estimates to change in the near term, and such a change could be material.

Furthermore, if we are not able to accurately and promptly anticipate and detect medical cost trends or accurately estimate the cost of incurred but not yet reported claims or reported claims that have not been paid, our ability to take timely corrective actions to limit future costs and reflect our current benefit cost experience in our pricing process may be limited, which would further exacerbate the extent of any adverse impact on our results of operations. These risks are particularly acute during and following periods when utilization of medical and/or other covered services and/or medical cost trends are below recent historical levels and in products where there is significant turnover in our membership each year, and such risks are further magnified by the ACA and other legislation and regulations that limit our ability to price for our projected and/or experienced increases in utilization and/or medical cost trends.

Extreme events, or the threat of extreme events, could materially increase our health care (including behavioral health) costs. We cannot predict whether or when any such events will occur.

Nuclear, biological or other attacks, whether as a result of war or terrorism, other man-made disasters, natural disasters, epidemics, pandemics and other extreme events can affect the United States economy in general, our industries and us specifically. In particular, such extreme events or the threat of such extreme events could result in significant health care (including behavioral health) costs, which would also be affected by the government's actions and the responsiveness of public health agencies and other insurers. In addition, our employees and those of our vendors are concentrated in certain large, metropolitan areas which may be particularly exposed to these events. Such events could adversely affect our businesses, cash flows and results of operations, and, in the event of extreme circumstances, our financial condition or viability, particularly if our responses to such events are less adequate than those of our competitors.

Changes in Public Policy and Other Legal and Regulatory Risks

Legislative and regulatory changes could create significant challenges to our Medicare Advantage and Medicare Part D revenues and results of operations, and proposed changes to these programs could create significant additional challenges. Entitlement program reform, if it occurs, could have a material adverse effect on our businesses, operations and/or results of operations.

Medicare Advantage payment rates to health plans have been cut over the last several years, with additional reductions to be phased in through 2019. CMS issued the Final Notice in April 2018. Overall, we project the benchmark rates in the Final Notice will increase funding for our Medicare Advantage business, excluding the impact of coding trend, by approximately 2.5 percent in 2019 compared to 2018. This 2019 rate increase only slightly offsets the challenge we face from the impact of the increasing cost of medical care (including prescription medications), the HIF and CMS local and national coverage decisions that require us to pay for services and supplies that are not

factored into our bids and creates continued pressure on the Medicare Advantage program and our Medicare Advantage results of operations. We cannot predict future Medicare funding levels, the impact of future federal budget actions or ensure that such changes or actions will not have an adverse effect on our Medicare results of operations.

In addition, the "star ratings" from CMS for our Medicare Advantage plans will continue to have a significant effect on our plans' results of operations. Since 2015, only Medicare Advantage plans with a star rating of four or higher (out of five) are eligible for a quality bonus in their basic premium rates. CMS continues to change its rating system to make achieving and maintaining a four or higher star rating more difficult. Our star ratings and past performance scores are adversely affected by the compliance issues that arise each year in our Medicare operations. If our star ratings fall below 4 for a significant portion of our Medicare Advantage membership or do not match the performance of our competitors or the star rating quality bonuses are reduced or eliminated, our revenues and results of operations may be significantly adversely affected.

Payments we receive from CMS for our Medicare Advantage and Part D businesses also are subject to risk adjustment based on the health status of the individuals we enroll. Elements of that risk adjustment mechanism continue to be challenged by the DOJ, the OIG and CMS itself. Substantial changes in the risk adjustment mechanism, including changes that result from enforcement or audit actions, could materially affect the fairness of our Medicare reimbursement, require us to raise prices or reduce the benefits we offer to Medicare beneficiaries, and potentially limit our (and the industry's) participation in the Medicare program.

Medicare Part D has resulted in increased utilization of prescription medications and puts pressure on our pharmacy gross margin rates due to regulatory and competitive pressures. Further, as a result of the ACA and changes to the retiree drug subsidy rules, clients of our PBM could decide to discontinue providing prescription drug benefits to their Medicare-eligible members. To the extent this phenomenon occurs, the adverse effects of increasing customer migration into Medicare Part D may outweigh the benefits we realize from growth of our Medicare Part D business. In addition, if the cost and complexity of Medicare Part D exceed management's expectations or prevent effective program implementation or administration; if changes to the regulations regarding how drug costs are reported for Medicare Part D are implemented in a manner that adversely affects the profitability of our Medicare Part D business; if changes to the applicable regulations impact our ability to retain fees from third parties including network pharmacies; if the government alters Medicare Part D program requirements or reduces funding because of the higher-than-anticipated cost to taxpayers of Medicare Part D or for other reasons; if the government mandates the use of point-of-sale manufacturer's rebates or up front drug pricing discounts, makes drug manufacturer's rebates illegal, or makes changes to how pharmacy pay-for-performance is calculated; or if reinsurance thresholds are reduced below their current levels, our Medicare Part D results of operations and our ability to expand our Medicare Part D business could be adversely affected.

More generally, our Medicare results of operations and our ability to expand our Medicare membership and revenues also could be adversely affected if we fail to design and maintain programs that are attractive to Medicare Advantage or Part D participants; if CMS imposes restrictions on our Medicare business as a result of audits or other regulatory actions; if we fail to successfully implement corrective actions or other remedial measures sufficient to prevent or remove any applicable restrictions that may be imposed by CMS; or if we are not successful in retaining enrollees, or winning contract renewals or new contracts under Medicare's competitive bidding process.

Federal funding for expanded Medicaid coverage began to decrease in 2017. This reduction is causing states to re-evaluate funding for their Medicaid expansions. That re-evaluation may adversely affect Medicaid payment rates, our Medicaid membership in those states, our revenues, our MBRs and our results of operations.

We may not be able to obtain adequate premium rate increases in our Insured Health Care Benefits products, which would have an adverse effect on our revenues, MBRs and results of operations and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes.

Premium rates for our Insured Health Care Benefits products generally must be filed with state insurance regulators and are subject to their approval, which creates risk for us in the current political and regulatory environment. The ACA generally requires a review by HHS in conjunction with state regulators of premium rate increases that exceed a federally specified threshold (or lower state-specific thresholds set by states determined by HHS to have adequate processes). Rate reviews can magnify the adverse impact on our operating margins and results of operations of increases in health care and other benefit costs, increased utilization of covered services, and ACA assessments, fees and taxes, by restricting our ability to reflect these increases and/or these assessments, fees and taxes in our pricing. The risk of increases in utilization of medical and/or other covered services and/or in health care and other benefit costs is particularly acute during and following periods when utilization has been below recent historical levels, during periods of changing economic conditions and/or employment levels and in products where there is significant turnover in our membership each year. Further, our ability to reflect ACA assessments, fees and taxes in our

Medicare rates is limited. Similarly, our ability to reflect them in our Medicaid and/or CHIP premium rates is limited due, among other things, to the budgetary pressures currently facing many state governments. This could magnify the adverse impact on our operating margins and results of operations of increases in utilization of medical and other covered services, health care and other benefit costs and/or medical cost trends that exceed our projections.

Since 2013, HHS has issued determinations to health plans that their rate increases were "unreasonable," and we continue to experience challenges to appropriate premium rate increases in certain states. Regulators or legislatures in a number of states have implemented or are considering limits on premium rate increases, either by enforcing existing legal requirements more stringently or proposing different regulatory standards. Regulators or legislatures in a number of states also have conducted hearings on proposed premium rate increases, which can result, in some instances have resulted, in substantial delays in implementing proposed rate increases even if they ultimately are approved. Our plans can be excluded from participating in small group Public Exchanges if they are deemed to have a history of "unreasonable" rate increases. We requested significant increases in our premium rates in our small group Commercial Health Care Benefits products for 2019 and expect to continue to request significant increases in those rates for 2020 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and significant assessments, fees and taxes imposed by the federal and state governments, including the ACA. Our rates also must be adequate to reflect the risk that our products will be selected by people with a higher risk profile or utilization rate than the pool of participants we anticipated when we established the pricing for the applicable products (also known as "adverse selection") in our products, particularly in small group products, which we expect to continue and potentially worsen in 2019 following the expiration of the ACA's risk corridor and reinsurance programs at the end of 2016. These significant rate increases heighten the risks of adverse public and regulatory reaction and adverse selection and the likelihood that our requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

We anticipate continued regulatory and legislative action to increase regulation of premium rates in our Insured Health Care Benefits products. We may not be able to obtain rates that are actuarially justified or that are sufficient to make our policies profitable in any product line or geography. If we are unable to obtain adequate rates and/or rate increases, it could materially and adversely affect our operating margins and our ability to earn adequate returns on Insured Health Care Benefits business in one or more states or cause us to withdraw from certain geographies and/or products.

Minimum MLR rebate requirements limit the level of margin we can earn in our Insured Health Care Benefits products while leaving us exposed to higher than expected medical costs. Challenges to our minimum MLR rebate methodology and/or reports could adversely affect our results of operations.

The ACA requires us to pay minimum MLR rebates each year with respect to prior years. The ACA's minimum MLR rebate requirements limit the level of margin we can earn in our Commercial Insured and Medicare Insured businesses. CMS minimum MLR rebate regulations limit the level of margin we can earn in our Medicaid Insured business. Certain portions of our Health Care Benefits Medicaid and FEHB program business also are subject to minimum MLR rebate requirements in addition to but separate from those imposed by the ACA. Minimum MLR rebate requirements leave us exposed to medical costs that are higher than those reflected in our pricing. The process supporting the management and determination of the amount of MLR rebates payable is complex and requires judgment, and the minimum MLR reporting requirements are detailed. Federal and state auditors are challenging our Commercial Health Care Benefits business' compliance with the ACA's minimum MLR requirements as well as our FEHB plans' compliance with the OPM's FEHB program-specific minimum MLR requirements. Our Medicare and Medicaid contracts also are subject to minimum MLR audits. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS. Additional challenges to our methodology and/or reports relating to minimum MLR and related rebates by federal and state regulators and private litigants are reasonably possible. The outcome of these audits and additional challenges could adversely affect our results of operations.

Our business activities are highly regulated. Our Pharmacy Services, Medicare Advantage, Medicare Part D, Medicaid, dual eligible, dual eligible special needs plan, small group and certain other products are subject to particularly extensive and complex regulations. If we fail to comply with applicable laws and regulations, we could be subject to significant adverse regulatory actions or suffer brand and reputational harm which may have a material adverse effect on our businesses. Compliance with existing and future laws, regulations and/or judicial decisions may reduce our profitability and limit our growth.

Our businesses are subject to extensive regulation and oversight by state, federal and international governmental authorities. The laws and regulations governing our operations and interpretations of those laws and regulations are increasing in number and complexity, change frequently and can be inconsistent or conflicting. In general, these laws and regulations are designed to benefit and protect customers, members and providers rather than us or our investors.

In addition, the governmental authorities that regulate our businesses have broad latitude to make, interpret and enforce the laws and regulations that govern us and continue to interpret and enforce those laws and regulations more strictly and more aggressively each year. In connection with the Aetna Acquisition, we also agreed to undertakings with certain state regulators that place various restrictions on certain of our businesses and the payment of dividends by certain of our subsidiaries.

Our Pharmacy Services products are subject to:

- The clinical quality, patient safety and other risks inherent in the dispensing, packaging and distribution of drugs and other health care products and services, including claims related to purported dispensing and other operational errors (any failure by us to adhere to the laws and regulations applicable to the dispensing of drugs could subject our Pharmacy Services businesses to civil and criminal penalties).

- Federal and state anti-kickback and other laws that govern our relationship with drug manufacturers, customers and consumers.

- Compliance requirements under ERISA, including fiduciary obligations in connection with the development and implementation of items such as drug formularies and preferred drug listings.

- Federal and state legislative proposals and/or regulatory activity that could adversely affect pharmacy benefit industry practices.

Our Health Care Benefits products are highly regulated, particularly those that serve Medicare, Medicaid, dual eligible, dual eligible special needs and small group Commercial customers and members. The laws and regulations governing participation in Medicare Advantage, Medicare Part D, Medicaid, dual eligible and dual eligible special needs plan programs are complex, are subject to interpretation and can expose us to penalties for non-compliance, including penalties under the False Claims Act and state false claims acts. In addition, the ACA may have expanded the jurisdiction of, and our exposure to, the False Claims Act to products that are sold on Public Exchanges or otherwise subject to the ACA. The scope of the practices and activities that are prohibited by federal and state false claims acts is the subject of pending litigation. Claims under federal and state false claims acts can be brought by the government or by private individuals on behalf of the government through a *qui tam* or "whistleblower" suit, and we are a defendant in a number of such proceedings. If we are convicted of fraud or other criminal conduct in the performance of a health program or if there is an adverse decision against us under the False Claims Act, we may be temporarily or permanently suspended from participating in government health care programs, including Medicare Advantage, Medicare Part D, Medicaid, dual eligible and dual eligible special needs plan programs, and we also may be required to pay significant fines and/or other monetary penalties.

If we fail to comply with laws and regulations that apply to government programs, we could be subject to criminal fines, civil penalties, premium refunds, prohibitions on marketing or active or passive enrollment of members, corrective actions, termination of our contracts or other sanctions which could have a material adverse effect on our ability to participate in Medicare Advantage, Medicare Part D, Medicaid, dual eligible, dual eligible special needs plan and other programs, cash flows, financial condition and results of operations.

Our businesses, profitability and growth also may be adversely affected by (i) judicial and regulatory decisions that change and/or expand the interpretations of existing statutes and regulations, impose medical or bad faith liability, increase our responsibilities under ERISA or the remedies available under ERISA, or reduce the scope of ERISA pre-emption of state law claims or (ii) other legislation and regulations.

If our compliance or other systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions or litigation which could adversely affect our businesses, results of operations, cash flows and/or financial condition.

Our businesses are subject to extensive and complex regulations, and many of our contracts with customers include detailed requirements. In order to be eligible to offer certain products or bid on certain contracts, we must demonstrate that we have robust systems in place to ensure that we comply with all applicable legal, regulatory and contractual requirements. These systems frequently are reviewed and audited by our customers and regulators. If our systems and processes designed to maintain compliance with applicable legal and contractual requirements, and to prevent and detect instances of, or the potential for, non-compliance fail or are deemed inadequate, we may suffer brand and reputational harm and be subject to regulatory actions, litigation and other proceedings which may result in damages, fines, suspension or loss of licensure, suspension or exclusion from participation in government programs and/or other penalties, any of which could adversely affect our businesses, cash flows, results of operations or financial condition.

Our litigation and regulatory risk profile are changing as a result of the Aetna Acquisition and as we offer new products and services and expand in business areas beyond our historical core businesses of Retail/LTC and Pharmacy Services.

Historically, we focused primarily on providing Retail/LTC and Pharmacy Services products and services. As a result of the Aetna Acquisition, we have significantly expanded our presence in Health Care Benefits products and services (including

products and services offered in multiple countries outside of the United States), which present a different litigation and regulatory risk profile than the products and services that we historically have offered.

The increased volume of business in areas beyond our historical core business and new products and services subject us to litigation and regulatory risks that are different from the risks of providing Retail/LTC and Pharmacy Services products and services and increase significantly our exposure to other risks.

We routinely are subject to litigation and other adverse legal proceedings, including class actions and qui tam actions. Many of these proceedings seek substantial damages which may not be covered by insurance. These proceedings may be costly to defend, result in changes in our business practices, harm our brand and reputation and adversely affect our businesses and results of operations.

Pharmacy services, retail pharmacy, LTC pharmacy and health care benefits are highly regulated and litigious industries. We are currently subject to various litigation matters, investigations, regulatory audits, inspections, government inquiries, and regulatory and other legal proceedings. Litigation, and particularly securities, collective or class action and *qui tam* litigation, is often expensive and disruptive. Certain of the lawsuits against us are or are purported to be class actions or *qui tam* actions. Litigation related to our provision of professional services in our pharmacies, specialty pharmacies, medical clinics and LTC facilities also has increased as we expand our services along the continuum of health care.

The majority of these proceedings relate to the conduct of our Retail/LTC, Pharmacy Services and Health Care Benefits operations and allege various violations of law. In addition, we operate in jurisdictions outside the United States, where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and are therefore more likely to be subject to dispute by customers, members, governmental authorities and others. We are incurring expenses to resolve these proceedings. The outcome of litigation and other adverse legal proceedings is always uncertain, and outcomes that are not justifiable by the evidence or existing law or regulation can and do occur.

Litigation has been and may be brought against us by private individuals on behalf of the government through a *qui tam* or "whistleblower" suit. Under the provisions of the federal and various state false claims acts, private citizens may bring lawsuits alleging that a violation of the federal anti-kickback statute or similar laws has resulted in the submission of "false" claims to federal and/or state health care programs, including Medicare and Medicaid, and we are a defendant in a number of such proceedings. When a private individual brings a whistleblower suit, the defendant often will not be made aware of the suit for many months or even years, until the government commences its own investigation or determines whether it will intervene. Whistleblower suits have resulted in significant settlements between governmental agencies and health care companies. The significant incentives and protections provided under the Financial Reform Act increase the risk of whistleblower suits.

Many of the legal proceedings against us seek substantial damages (including non-economic or punitive damages and treble damages), and certain of these proceedings also seek changes in our business practices. While we currently have insurance coverage for some potential liabilities, other potential liabilities may not be covered by insurance, insurers may dispute coverage, or the amount of our insurance may not be enough to cover the damages awarded or costs incurred. In addition, some types of damages, like punitive damages, may not be covered by insurance, and in some jurisdictions the coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability may become unavailable or prohibitively expensive in the future.

We cannot predict the outcome of any of these matters, and the costs incurred may be substantial regardless of outcome. Litigation and other adverse legal proceedings could materially adversely affect our businesses or results of operations because of brand and reputational harm to us caused by such proceedings, the costs of defending such proceedings, the costs of settlement or judgments against us, or the changes in our operations that could result from such proceedings. See Item 3 of this Annual Report on Form 10-K for additional information.

We frequently are subject to regular and special governmental audits, investigations and reviews that could result in changes to our business practices and also could result in material refunds, fines, penalties, civil liabilities, criminal liabilities and other sanctions.

As one of the largest national retail and LTC pharmacy, pharmacy services and health care benefits providers, we frequently are subject to regular and special governmental market conduct and other audits, investigations and

reviews by, and we receive subpoenas and other requests for information from, various federal and state agencies, regulatory authorities, attorneys general, committees, subcommittees and members of the United States Congress and other state, federal and international governmental authorities. For example, we have received CIDs from, and provided documents and information to, the Civil Division of the

DOJ in cooperation with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. Several such audits, investigations and reviews currently are pending, some of which may be resolved in 2019, and the results of which may be adverse to us.

Federal and state governments have made investigating and prosecuting health care and other insurance fraud, waste and abuse a priority. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical and/or other covered services, improper marketing and violations of patient privacy rights. The regulations and contractual requirements applicable to us and other industry participants are complex and subject to change, making it necessary for us to invest significant resources in complying with our regulatory and contractual requirements. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources. In addition, our medical costs and the medical expenses of our Health Care Benefits ASC customers may be adversely affected if we do not prevent or detect fraudulent activity by providers and/or members.

Regular and special governmental audits, investigations and reviews by federal, state and international regulators could result in changes to our business practices, and also could result in significant or material premium refunds, fines, penalties, civil liabilities, criminal liabilities or other sanctions, including suspension or exclusion from participation in government programs and suspension or loss of licensure. Any of these audits, investigations or reviews could have a material adverse effect on our financial condition, results of operations or businesses or result in significant liabilities and negative publicity for our company. For example, since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various years for RADV audit. In addition, federal and state auditors are challenging our Commercial Health Care Benefits business' compliance with the ACA's minimum MLR requirements as well as our FEHB plans' compliance with OPM's FEHB program-specific minimum MLR requirements. Our Medicare and Medicaid contracts also are subject to minimum MLR audits. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS.

We are subject to retroactive adjustments to and/or withholding of certain premiums and fees, including as a result of CMS RADV audits. We generally rely on health care providers to appropriately code claim submissions and document their medical records. If these records do not appropriately support our risk adjusted premiums, we may be required to refund premium payments to CMS and/or pay fines and penalties under the False Claims Act.

Premiums and/or fees for Medicare members, certain federal government employee groups and Medicaid beneficiaries are subject to retroactive adjustments and/or withholding by the federal and applicable state governments. Our business that is subject to the ACA, including amounts payable to us or payable by us under the ACA's premium stabilization programs and our risk adjustment and reinsurance data, also is subject to audit by governmental authorities. CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of the services we provide to our Medicare members.

CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions to us and document their medical records, including the diagnosis data submitted to us with claims. CMS pays increased premiums to Medicare Advantage plans and PDPs for members who have certain medical conditions identified with specific diagnosis codes.

Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted RADV audits of a subset of Medicare Advantage plans for various contract years, including certain of our plans for various contract years, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require us to refund premium payments if our risk adjusted premiums are not properly supported by medical record data. The OIG also is auditing our risk adjustment data and that of other companies, and we expect CMS and the OIG to continue auditing risk adjustment data. We also have received CIDs from, and provided documents and information to, the Civil Division of the DOJ in connection with a current investigation of our patient

chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified

in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. For contract years prior to 2011, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase our exposure to premium refunds to CMS based on incomplete medical records maintained by providers. On October 26, 2018, CMS issued proposed rules related to, among other things, changes to the RADV audit methodology established by CMS in 2012. CMS projects that the changes to the RADV audit methodology would increase its recoveries from Medicare Advantage plans as a result of RADV audits. CMS has requested comments on the proposed rules, including whether the proposed RADV rule change should apply retroactively to audits of Medicare Advantage plans for contract year 2011 and forward. We are evaluating the potential adverse effect, which could be material, on our results of operations, financial condition and cash flows if the proposed RADV rule change were adopted as proposed. CMS also has announced its intent to use third party auditors to attain its ultimate goal of subjecting all Medicare Advantage contracts to either a comprehensive or a targeted RADV audit for each contract year. We are currently unable to predict which of our Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect of any such refunds or adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would require us to change our method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in our bids for prior contract years, the current contract year or future contract years.

If we fail to report and correct errors discovered through our own auditing procedures or during a CMS audit or otherwise fail to comply with the applicable laws and regulations, we could be subject to fines, civil monetary penalties or other sanctions, including fines and penalties under the False Claims Act, which could have a material adverse effect on our ability to participate in Medicare Advantage, Part D or other government programs, and on our financial condition, cash flows and results of operations.

CMS has issued a final rule implementing ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. However, CMS's statements in formalized guidance regarding "overpayments" to Medicare Advantage plans appear to be inconsistent with CMS's prior RADV audit guidance. These statements appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without reconciliation to the principles underlying the fee for service adjustment comparison contemplated by CMS's RADV audit methodology. The precise interpretation, impact and legality of the final rule are not clear and are subject to pending litigation. If Medicare Advantage plans were not paid based on payment model principles that align with the requirements of the Social Security Act or such payments were not implemented correctly, it could have a material adverse effect on our results of operations, financial condition and/or cash flows.

Certain of our Medicaid contracts require the submission of complete and correct encounter data. The accurate and timely reporting of encounter data is increasingly important to the success of our Medicaid programs because more states are using encounter data to determine compliance with performance standards and, in part, to set premium rates. We have expended and may continue to expend additional effort and incur significant additional costs to collect accurate, or to correct inaccurate or incomplete, encounter data and have been and could be exposed to premium withholding, operating sanctions and financial fines and penalties for noncompliance. We have experienced challenges in obtaining complete and accurate encounter data due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could affect the Medicaid premium rates we receive and how Medicaid membership is assigned to us, which could have a material adverse effect on our Medicaid results of operations and cash flows and/or our ability to bid for, and continue to participate in, certain Medicaid programs.

Any premium or fee refunds, adjustments or withholding or civil or criminal fines or penalties, or other sanctions, including restrictions on or changes in the way we do business, loss of licensure or exclusion from participation in government programs, resulting from regulatory audits or investigations, whether as a result of RADV, Public Exchange related, recovery audit program or other audits or investigations by CMS, the OIG, HHS, the DOJ or otherwise, including audits of our minimum MLR rebates, methodology and/or reports, could be material and could adversely affect our results of operations, financial condition and cash flows.

Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues. The U.S. federal government and our other government customers may reduce funding for health care or other programs, cancel or decline to renew contracts with us, or make changes that adversely affect the number of persons eligible for certain programs, the services provided to enrollees in such programs, our premiums and

our administrative and health care and other benefit costs, any of which could have a material adverse effect on our businesses, results of operations and cash flows. In addition, an extended federal government shutdown or a delay by Congress in raising the federal government's debt ceiling could lead to a delay, reduction, suspension or cancellation of federal government spending and a

significant increase in interest rates that could, in turn, have a material adverse effect on our businesses, results of operations and cash flows.

Programs funded in whole or in part by the United States federal government account for a significant portion of our revenue, and we expect that percentage to increase. As our government funded businesses grow, our exposure to changes in federal and state government policy with respect to and/or regulation of the various government funded programs in which we participate also increases.

Our revenues from government funded programs, including our Medicare, Medicaid, dual eligible and dual eligible special needs plan businesses and our government customers in our Commercial business, are dependent on annual funding by the federal government and/or applicable state or local governments. Federal, state and local governments have the right to cancel or not to renew their contracts with us on short notice without cause or if funds are not available. Funding for these programs is dependent on many factors outside our control, including general economic conditions, continuing government efforts to contain health care costs and budgetary constraints at the federal or applicable state or local level and general political issues and priorities.

For example, CMS is transitioning the process of calculating Medicare members' risk scores from using diagnoses data from the Risk Adjustment Processing System, or RAPS, to using diagnoses data from the Encounter Data System, or EDS. The RAPS process requires Medicare Advantage plans to apply a filter logic based on CMS guidelines and only submit claims that satisfy those guidelines. For submissions through EDS, CMS requires Medicare Advantage plans to submit all encounter data, and CMS applies the risk adjustment filtering logic to determine the risk scores. For 2019, 25% of the risk score will be calculated from claims data submitted through EDS, up from 15% in 2018. For 2020, the EDS percentage will increase to 50%. The transition from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues or filtering logic differences between RAPS and EDS and could have a material adverse effect on our results of operations, financial condition and/or cash flows.

In addition, while the ACA provided substantial federal funding for the expansion of the number of people who qualify to enroll in Medicaid beginning in 2014, that funding began to decrease in 2017, and the future of that funding is uncertain. As a result, in 2019, states are preparing for the adverse impact on their budgets and programs by seeking to reduce their Medicaid expenditures and/or changing the design of their Medicaid programs. These changes could have a material adverse effect on the revenues, medical benefit ratios and results operations of our Medicaid contracts and/or our ability to grow our Medicaid membership, revenues and results of operations.

Our government customers also determine the eligibility criteria, premium levels and other aspects of Medicare, Medicaid, dual eligible and dual eligible special needs plan programs that affect the number of persons enrolled in these programs, the services provided to enrollees under these programs, the conditions for participating in these programs and our administrative and health care and other benefit costs under these programs. For example, states may require participation on their Public Exchange as a condition to participating in their Medicaid or state employee health benefit programs and/or take program design actions that shift provider costs from state employee plans to Commercial and Medicare plans. In the past, determinations of this type have at times adversely affected our results of operations from and willingness to participate in such programs, and they may do so again in the future. If a government customer reduces premium levels or increases premiums by less than the increase in our costs (such as by not allowing us to recover ACA and other applicable fees, taxes and assessments), and we cannot offset the adverse impact of these actions with supplemental premiums and/or changes in benefit plans, then our businesses and results of operations could be adversely affected. In addition, if states allow certain programs to expire, reduce the number of firms with which they contract for Managed Medicaid services or choose to opt out of Medicaid expansion, we could experience reduced Medicaid enrollment or reduced Medicaid enrollment growth, which would adversely affect our businesses, revenues and results of operations.

The federal government's "debt ceiling", or the amount of debt the federal government is permitted to borrow to meet its legal obligations (including, among other things, interest on the national debt, Medicare and Medicaid premiums and contributions to the FEHB program), is limited by statute and can only be raised by an act of Congress.

During a federal government shutdown or if Congress does not raise the debt ceiling before the federal government's current obligations approach or exceed its cash on hand and incoming receipts, federal government spending may be subject to delay, reduction, suspension or cancellation, which may be prolonged. Over 30% of our Health Care

Benefits segment's revenues are derived from health care coverage programs that are funded in whole or in part by the federal government, including the Medicare, Medicaid, dual eligible and dual eligible specials needs plan programs, CHIP and the FEHB program. When federal spending is delayed, suspended or curtailed, we continue to receive claims from providers providing services to beneficiaries of these programs, and we remain liable for, and are required to fund, such claims. A federal government shutdown or a failure to

timely raise the debt ceiling could have a material adverse effect on our businesses, results of operations, cash flows, brand and reputation and, in the case of a prolonged shutdown or failure to raise the debt ceiling, our financial condition.

If the United States defaults on its obligations due to a failure to timely raise the debt ceiling or otherwise, or its credit rating is downgraded by any of the credit rating agencies, interest rates could rise, financial markets could become volatile and/or the availability of credit (and short-term credit in particular) could be adversely affected, thereby increasing our borrowing costs, adversely affecting the value of our investment portfolio, and/or adversely affecting our ability to access the capital markets, which could have a material adverse effect on our results of operations, financial condition and cash flows and could adversely affect our liquidity.

Our results of operations may be adversely affected by changes in laws and policies governing employers and by union organizing activity.

The federal and certain state legislatures continue to consider and pass legislation that increases our costs of doing business, including increased minimum wages and requiring employers to provide paid sick leave. In addition, our employee related operating costs may be increased by union organizing activity. If we are unable to reflect these increased expenses in our pricing or otherwise modify our operations to mitigate the effects of such increases, our results of operations will be adversely affected.

Risks Related to Customer Perceptions of our Products and Services

We must develop and maintain a relevant omni-channel experience for our retail customers.

Our business has evolved from a retail store experience to interaction with customers across numerous channels, including in-store, online, mobile and social media, among others. Omni-channel retailing is rapidly evolving and we must keep pace with changing customer expectations and new developments by our competitors. Our customers are increasingly using mobile phones, tablets, computers and other devices to comparison shop, determine product availability and complete purchases through mobile commerce applications. As a result, the portion of total consumer expenditures with all retailers occurring online and through mobile commerce applications is increasing and the pace of this increase could accelerate. We must compete by offering a consistent and convenient shopping experience for our customers regardless of the ultimate sales channel and by investing in, providing and maintaining mobile commerce applications for our customers that have the right features and are reliable and easy to use. If we are unable to make, improve or develop relevant customer-facing technology in a timely manner that keeps pace with technological developments and dynamic customer expectations, our ability to compete and our results of operations could be materially and adversely affected. In addition, if our online activities or our other customer-facing technology systems do not function as designed, we may experience a loss of customer confidence, data security breaches, lost sales, or be exposed to fraudulent purchases, any of which could materially and adversely affect our business operations, reputation and results of operations.

We must maintain and improve our relationships with our retail and specialty pharmacy customers and increase the demand for our products and services, including proprietary brands. If we fail to develop new products, differentiate our products from those of our competitors or demonstrate the value of our products to our customers and members, our ability to retain or grow our customer base may be adversely affected.

The success of our businesses depends in part on customer loyalty, superior customer service and our ability to persuade customers to frequent our retail stores and online sites and to purchase products in additional categories and our proprietary brands. Failure to timely identify or effectively respond to changing consumer preferences and spending patterns, and evolving demographic mixes in our markets, an inability to expand the products being purchased by our clients and customers, or the failure or inability to obtain or offer particular categories of products could adversely affect our relationship with our customers and clients and the demand for our products and services and could result in excess inventories of products.

We offer our retail customers proprietary brand products that are available exclusively at our retail stores and through our online retail sites. The sale of proprietary products subjects us to unique risks including potential product liability risks, mandatory or voluntary product recalls, potential supply chain and distribution chain disruptions for raw materials and finished products, our ability to successfully protect our intellectual property rights and the rights of applicable third parties, and other risks generally encountered by entities that source, market and sell private-label

products. Any failure to adequately address some or all of these risks could have an adverse effect on our retail business, results of operations and financial condition. Additionally, an increase in the sales of our proprietary brands may adversely affect our sales of products owned by our suppliers which, consequently, could adversely impact certain of our supplier relationships. Our ability to locate qualified, economically stable suppliers who satisfy our requirements, and to acquire sufficient products in a timely and effective manner,

is critical to ensuring, among other things, that customer confidence is not diminished. Any failure to develop sourcing relationships with a broad and deep supplier base could adversely affect our financial performance and erode customer loyalty.

Our specialty pharmacy business focuses on complex and high-cost medications, many of which are made available by manufacturers to a limited number of pharmacies (so-called limited distribution drugs), that serve a relatively limited universe of patients. As a result, the future growth of our specialty pharmacy business is dependent largely upon expanding our base of drugs or penetration in certain treatment categories. Any contraction of our base of patients or reduction in demand for the prescriptions we currently dispense could have an adverse effect on our specialty pharmacy business, results of operations and cash flows.

We operate in rapidly evolving industries. Our customers generally, and our larger customers in particular, are well-informed and organized and, along with our individual customers, can easily move between us and our competitors. These factors require us to differentiate our products and solutions, anticipate changes in customer and consumer preferences, anticipate and effectively compete with the products and solutions of new and existing competitors and innovate and deliver new and existing products and solutions that demonstrate value to our customers and members, particularly in response to marketplace changes from public policy. Any failure to do so may adversely affect our ability to retain or grow customers and/or profitable medical membership, which can adversely affect our results of operations.

In order to be competitive in the increasingly consumer-oriented marketplace for our health care products and services, we will need to develop and deploy consumer-friendly products and services and make investments in consumer engagement, reduce our cost structure and compete successfully with new entrants into our businesses. If we are unsuccessful, our future growth and profitability may be adversely affected.

Historically, employers have been the most significant customers driving purchases of our Pharmacy Services and Health Care Benefits segments. However, decisions to buy our Pharmacy Services and Health Care Benefits products and services increasingly are made or influenced by consumers, either through direct purchasing (for example, Medicare Advantage plans and PDPs) or through Insurance Exchanges that allow individual choice. Similarly, consumers increasingly seek to access health care products and services locally and through other direct channels such as mobile devices and our websites. In response to this demand, we are expanding our consumer focus. To compete effectively in the consumer-driven marketplace, we will be required to develop or acquire new capabilities, attract new talent and develop new service and distribution relationships that respond to consumer needs and preferences.

We also will have to respond to pricing and other actions taken by existing competitors as well as potentially disruptive new entrants. Regulatory and participation requirements for Insurance Exchange-based plans tend to emphasize price and make competitive differentiation of our Health Care Benefits products and services based on other attributes more difficult. Price competition from existing and potentially new disruptive competitors in the industries in which each of our segments compete also continues to increase. Accordingly, we face competitive pricing pressures from existing and new competitors (including our vendors and others who may have lower cost structures than we do), and these pressures may reduce our operating margins or limit sales of our products and services. Our competitors may bring their consumer-oriented products and services to market more quickly, have greater experience marketing to consumers and/or may be targeting the higher margin portions of our businesses. These risks may be enhanced if employers shift to defined contribution health care benefits plans and make greater utilization of Private Exchanges or encourage their employees to purchase health insurance on the Public Exchanges. We can provide no assurance that we will be able to develop or operate successful or profitable consumer-oriented products and services, or that our Health Care Benefits segment will be able to compete successfully or profitably on Public Exchanges or Private Exchanges or benefit from any opportunities presented by Public Exchanges or Private Exchanges, or that we will be able to benefit from opportunities available to any of our segments in the industries in which we operate. If we do not develop and expand competitive and profitable consumer products, are not competitive in the industries in which we operate, or are unsuccessful in reducing our cost structure, our future growth and profitability may be adversely affected.

Risks Related to Our Relationships with Manufacturers, Providers, Suppliers and Vendors

Our results of operations may be adversely affected if we are unable to contract with manufacturers, providers, suppliers and vendors on competitive terms and develop and maintain attractive networks with high quality providers.

Our PBM business generates revenues primarily by contracting with clients to provide prescription drugs and related health care services to plan members. As a result, we are dependent on our relationships with prescription drug manufacturers and suppliers. We acquire a substantial amount of our mail order and specialty pharmacies' prescription drug supply from a limited number of suppliers. Our agreements with these suppliers often are short-term and easily cancelable by either party without cause. In addition, these agreements may limit our ability to provide services for competing drugs during the term of the

agreement and may allow the supplier to distribute through channels other than the Company. A termination or modification to any of these relationships could have a material adverse effect on our businesses, financial condition and results of operations.

We are seeking to enhance our health care provider networks by entering into joint ventures and other collaborative risk-sharing arrangements with health care providers. Providers' willingness to enter these arrangements with us depends upon, among other things, our ability to provide them with up to date quality of care data to support these value-based contracts. These arrangements are designed to give providers incentives to engage in population health management and optimize delivery of health care to our members. These arrangements also may allow us to expand into new geographies, target new customer groups, increase membership and reduce medical costs and, if we provide technology or other services to the relevant health system or provider organization, may contribute to our revenue and earnings from alternative sources. If such arrangements do not result in the lower medical costs that we project or if we fail to attract health care providers to such arrangements, or are less successful at implementing such arrangements than our competitors, our medical costs may not be competitive and may be higher than we project, our attractiveness to customers may be reduced, we may lose or be unable to grow membership, and our ability to profitably grow our business and/or our results of operations may be adversely affected.

While we believe joint ventures, ACOs and other non-traditional health care provider organizational structures present opportunities for us, the implementation of our joint ventures and other non-traditional structure strategies may not achieve the intended results, which could adversely affect our results of operations and cash flows. Among other things, joint ventures require us to maintain collaborative relationships with our counterparties, continue to gain access to provider rates that make the joint ventures economically sustainable and devote significant management time to the operation and management of the joint venture. We may not be able to achieve these objectives in one or more of our joint ventures, which could adversely affect our results of operations and cash flows.

If our service providers fail to meet their contractual obligations to us or to comply with applicable laws or regulations, we may be exposed to brand and reputational harm, litigation or regulatory action. This risk is particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs.

We contract with various third parties to perform certain functions and services and provide us with certain information technology systems. Our arrangements with these third parties may expose us to public scrutiny, adversely affect our brand and reputation, expose us to litigation or regulatory action, and otherwise make our operations vulnerable if we fail to adequately oversee, monitor and regulate their performance or if they fail to meet their contractual obligations to us or to comply with applicable laws or regulations. For example, certain of our vendors have been responsible for releases of sensitive information of our members and employees, which has caused us to incur additional expenses and given rise to litigation against us.

These risks are particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs, where third parties perform PBM, medical management and other member related services for us. Any failure of our or these third parties' prevention, detection or control systems related to regulatory compliance, compliance with our internal policies, data security and/or cybersecurity or any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, members', customers' or other constituents' sensitive information could require us to expend significant resources to remediate any damage, interrupt our operations and adversely affect our brand and reputation and also expose us to whistleblower, class action and other litigation, other proceedings, prohibitions on marketing or active or passive enrollment of members, corrective actions, fines, sanctions and/or penalties, any of which could adversely affect our businesses, cash flows, results of operations and/or financial condition.

Continuing consolidation and integration among providers and other suppliers may increase our medical and other covered benefits costs, make it difficult for us to compete in certain geographies and create new competitors.

Hospitals and other providers and health systems continue to consolidate across the health care industry. While this consolidation could increase efficiency and has the potential to improve the delivery of health care services, it also reduces competition and the number of potential contracting parties in certain geographies. These health systems also are increasingly forming and considering forming health plans to directly offer health insurance in competition with us, a process that has been accelerated by the ACA. In addition, ACOs (including commercial and Medicaid-only ACOs developed as a result of state Medicaid laws), practice management companies, consolidation among and by integrated health systems and other changes in the organizational structures that physicians, hospitals and other

health care providers adopt continues to change the way these providers interact with us and the competitive landscape in which we operate. These changes may increase our medical and other covered benefits costs, may affect the way we price our products and services and estimate our medical and other covered benefits costs and may require us to change our operations, including by withdrawing from certain geographies where we do not have a significant presence across our businesses or are unable to collaborate or contract with providers on acceptable terms. Each of these changes may adversely affect our businesses and results of operations.

We may experience increased medical and other benefit costs, litigation risk and customer and member dissatisfaction when providers that do not have contracts with us render services to our Health Care Benefits members.

Some providers that render services to our Health Care Benefits members do not have contracts with us. In those cases, we do not have a pre-established understanding with these providers as to the amount of compensation that is due to them for services rendered to our members. In some states, the amount of compensation due to these nonparticipating providers is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover the difference between what we have paid them and the amount they charged us from our members, which may result in customer and member dissatisfaction. For example, on October 15, 2018, an arbitrator awarded certain claimant hospitals approximately $150 million in a proceeding relating to Aetna's out-of-network benefit payment and administration practices. Such disputes may cause us to pay higher medical or other benefit costs than we projected.

Risks Related to Our Operations

Customers, particularly large sophisticated customers, expect us to implement their contracts and onboard their employees and members efficiently and effectively. Failure to do so could adversely affect our reputation, businesses, results of operations, cash flows and prospects. If we or our vendors fail to provide our customers with quality service that meets their expectations, our ability to retain and grow our membership and customer base will be adversely affected.

Our ability to attract and retain customers and members is dependent upon providing cost effective, quality customer service operations (such as call center operations, PBM functions, retail pharmacy and LTC services, home delivery pharmacy prescription delivery, specialty pharmacy prescription delivery, claims processing, customer case installation and online access and tools) that meet or exceed our customers' and members' expectations. As we seek to reduce general and administrative expenses, we must balance the potential impact of cost-saving measures on our customer and other service and performance. If we misjudge the effects of such measures, customer and other service may be adversely affected. We depend on third parties for certain of our customer service, PBM and prescription delivery operations. If we or our vendors fail to provide service that meets our customers' and members' expectations, we may have difficulty retaining or profitable growing our customer base and/or membership, which can adversely affect our results of operations. For example, noncompliance with any privacy or security laws or regulations or any security breach involving one of our third party vendors could have a material adverse effect on our businesses, results of operations, brand and reputation.

We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.

We accept payments using a variety of methods, including cash, checks, credit cards, debit cards, gift cards, mobile payments and potentially other technologies in the future. Acceptance of these payment methods subjects us to rules, regulations, contractual obligations and compliance requirements, including payment network rules and operating guidelines, data security standards and certification requirements, and rules governing electronic funds transfers. These requirements may change in the future, which could make compliance more difficult or costly. For certain payment options, including credit and debit cards, we pay interchange and other fees, which could increase periodically thereby raising our operating costs. We rely on third parties to provide payment processing services, including the processing of credit cards, debit cards, and various other forms of electronic payment. If these vendors are unable to provide these services to us, or if their systems are compromised, our operations could be disrupted. The payment methods that we offer also expose us to potential fraud and theft by persons seeking to obtain unauthorized access to, or exploit any weaknesses in, the payment systems we use. If we fail to abide by applicable rules or requirements, or if data relating to our payment systems is compromised due to a breach or misuse, we may be responsible for any costs incurred by payment card issuing banks and other third parties or subject to fines and higher transaction fees. In addition, our reputation and ability to accept certain types of payments could each be harmed resulting in reduced sales and adverse effects on our results of operations.

Our and our vendors' operations are subject to a variety of business continuity hazards and risks, any of which could interrupt our operations or otherwise adversely affect our performance and results of operations.

We and our vendors are subject to business continuity hazards and other risks, including natural disasters, utility and other mechanical failures, acts of war or terrorism, disruption of communications, data security and preservation, disruption of supply or distribution, safety regulation and labor difficulties. The occurrence of any of these or other events to the Company or our vendors might disrupt or shut down our operations or otherwise adversely affect our operations. We may also be subject to certain liability claims in the event of an injury or loss of life, or damage to property, resulting from such events. Although we

have developed procedures for crisis management and disaster recovery and business continuity plans and maintain insurance policies that we believe are customary and adequate for our size and industry, our insurance policies include limits and, as such, our coverage may be insufficient to protect against all potential hazards and risks incident to our businesses. In addition, our crisis management and disaster recovery procedures and business continuity plans may not be effective. Should any such hazards or risks occur, or should our insurance coverage be inadequate or unavailable, our businesses, financial condition and results of operations could be adversely affected.

We and our vendors have experienced cyber attacks. We can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future.

We and our vendors have experienced and continue to experience a variety of cyber attacks, and we and our vendors expect to continue to experience cyber attacks going forward. Among other things, we and our vendors have experienced automated attempts to gain access to our public facing networks, brute force, SYN flood and distributed denial of service attacks, attempted malware infections, vulnerability scanning, ransomware attacks, spear-phishing campaigns, mass reconnaissance attempts, injection attempts, phishing, PHP injection and cross-site scripting. We also have seen an increase in attacks designed to obtain access to consumers' accounts using illegally obtained demographic information. Although the impact of such attacks has not been material to our operations or results of operations through December 31, 2018, we can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future. As we expand our consumer-oriented products and services, increase the amount and types of data we acquire, generate and use, increase the amount of information we make available to members, consumers and providers on mobile devices, expand our use of vendors, expand internationally and expand our use of social media, our exposure to these data security and related cybersecurity risks, including the risk of undetected attacks, damage, loss or unauthorized disclosure or access to and/or disruption of our systems and the customer, member, provider, employee, ACO, joint venture, vendor and other third party information they contain, increases, and the cost of attempting to protect against these risks also increases.

Although we deploy a layered approach to address information security (including cybersecurity) threats and vulnerabilities that is designed to protect confidential information against data security breaches, a compromise of our information security controls or of those businesses with whom we interact, which results in confidential information being accessed, obtained, damaged, or used by unauthorized or improper persons, could harm our reputation and expose us to regulatory actions and claims from customers and clients, financial institutions, payment card associations and other persons, any of which could adversely affect our businesses, financial condition, and results of operations. Because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may not immediately produce signs of intrusion, we may be unable to anticipate these techniques or to implement adequate preventative measures. Moreover, a data security breach could require that we expend significant resources related to our information systems and infrastructure, and could distract management and other key personnel from performing their primary operational duties. We also could be adversely affected by any significant disruption in the systems of third parties we interact with, including key payors and vendors.

The costs of attempting to protect against the foregoing risks and the costs of responding to a cyber-incident are significant. Large scale data breaches at other entities increase the challenge we and our vendors face in maintaining the security of our information technology systems and proprietary information and of our members' and customers' sensitive information. Following a cyber-incident, our and/or our vendors' remediation efforts may not be successful, and a cyber-incident could result in interruptions, delays or cessation of service, and loss of existing or potential customers and members. In addition, breaches of our and/or our vendors' security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about us, our customers, our members or other third-parties, could expose our customers' and members' private information and our customers and members to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, and result in investigations, regulatory enforcement actions, material fines and penalties, loss of customers, litigation or other actions which could have a material adverse effect on our businesses, brand, reputation, cash flows and results of operations.

The failure or disruption of our information technology systems or the failure of our information technology infrastructure to support our businesses could adversely affect our reputation, businesses, results of operations and cash flows.

Our information systems are subject to damage or interruption from power outages, facility damage, computer and telecommunications failures, computer viruses, security breaches (including credit card or personally identifiable information breaches), cyber attacks, vandalism, catastrophic events and human error. If our information systems are damaged, fail to work properly or otherwise become unavailable, or if we are unable to successfully complete our planned consolidation of our PBM

claims adjudication platforms, we may incur substantial costs to repair or replace them, and may experience reputational damage, loss of critical information, customer disruption and interruptions or delays in our ability to perform essential functions and implement new and innovative services. In addition, compliance with changes in United States and foreign privacy and information security laws and standards may result in considerable expense due to increased investment in technology and the development of new operational processes.

Our business success and results of operations depend in part on effective information technology systems and on continuing to develop and implement improvements in technology. Pursuing multiple initiatives simultaneously could make this continued development and implementation significantly more challenging.

Many aspects of our operations are dependent on our information systems and the information collected, processed, stored, and handled by these systems. We rely heavily on our computer systems to manage our ordering, pricing, point-of-sale, pharmacy fulfillment, inventory replenishment, claims processing, ExtraCare customer loyalty program, finance and other processes. Throughout our operations, we receive, retain and transmit certain confidential information, including PII and PHI, that our customers and clients provide to purchase products or services, enroll in programs or services, register on our websites, interact with our personnel, or otherwise communicate with us. In addition, for these operations, we depend in part on the secure transmission of confidential information over public networks.

We have many different information and other technology systems supporting our businesses (including as a result of our acquisitions). Our businesses depend in large part on these systems to adequately price our products and services; accurately establish reserves, process claims and report results of operations; and interact with providers, employer plan sponsors, members and vendors in an efficient and uninterrupted fashion. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Certain of our technology systems (including software) are older, legacy systems that are less flexible, less efficient and require a significant ongoing commitment of capital and human resources to maintain, protect and enhance them and to integrate them with our other systems. We must re-engineer and reduce the number of these systems to meet changing consumer and vendor preferences and needs, improve our productivity and reduce our operating expenses. We also need to develop or acquire new technology systems, contract with new vendors or modify certain of our existing systems to support the consumer-oriented products and services we are developing, operating and expanding and/or to meet current and developing industry and regulatory standards, including to keep pace with continuing changes in information processing technology and emerging cybersecurity risks and threats. If we fail to achieve these objectives, our ability to profitably grow our business and/or our results of operations may be adversely affected.

Our business strategy involves providing customers with differentiated, easy to use, secure products and solutions that use information to meet customer needs. The types of technology and levels of service that are acceptable to customers and members today will not necessarily be acceptable in the future, requiring us to anticipate and meet marketplace demands for technology. Our success therefore is dependent in large part on our ability, within the context of a limited budget of human resources and capital and our existing and future business relationships, to timely secure, integrate, develop, redesign and enhance our (or contract with vendors to provide) technology systems that support our business strategy initiatives and processes in a compliant, secure, and cost and resource efficient manner. Integration of our acquisitions increases these challenges, and we may not be successful in integrating various systems in a timely or cost-effective manner.

Information technology projects frequently are long-term in nature and may take longer to complete and cost more than we expect and may not deliver the benefits we project once they are complete. If we do not effectively and efficiently secure, manage, integrate and enhance our technology portfolio (including vendor sourced systems), we could, among other things, have problems determining health care and other benefit cost estimates and/or establishing appropriate pricing, meeting the needs of customers, providers and members, developing and expanding our consumer-oriented products and services or keeping pace with industry and regulatory standards, and our results of operations may be adversely affected.

Sales of our products and services are dependent on our ability to attract and motivate internal sales personnel and independent third-party brokers, consultants and agents. New distribution channels create new disintermediation risk. We may be subject to penalties or other regulatory actions as a result of the marketing practices of brokers and agents selling our products.

Our products are sold primarily through our sales personnel, who frequently work with independent brokers, consultants and agents who assist in the production and servicing of business. The independent brokers, consultants and agents generally are not dedicated to us exclusively and may frequently recommend and/or market health care benefits products of our competitors. Accordingly, we must compete intensely for their services and allegiance. Our sales could be adversely affected if we are unable to attract, retain or motivate sales personnel and third-party brokers, consultants and agents, or if we do not adequately

provide support, training and education to this sales network regarding our complex product portfolio, or if our sales strategy is not appropriately aligned across distribution channels. This risk is heightened as we develop, operate and expand our Consumer Health Products and Services products and services and our business model evolves to include a greater focus on consumers and direct-to-consumer sales, such as competing for sales on Insurance Exchanges.

New distribution channels for our products and services continue to emerge, including Private Exchanges operated by health care consultants and technology companies. These channels may make it more difficult for us to directly engage consumers and other customers in the selection and management of their health care benefits, in health care utilization and in the effective navigation of the health care system. We also may be challenged by new technologies and marketplace entrants that could interfere with our existing relationships with customers and health plan members in these areas.

In addition, there have been a number of investigations regarding the marketing practices of brokers and agents selling health care and other insurance products and the payments they receive. These investigations have resulted in enforcement actions against companies in our industry and brokers and agents marketing and selling those companies' products. For example, CMS and state departments of insurance have increased their scrutiny of the marketing practices of brokers and agents who market Medicare products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans and/or changes to industry practices, which could adversely affect our ability to market our products.

We also face other risks that could adversely affect our businesses, results of operations, financial condition and/or cash flows, which include:

- Failure of our corporate governance policies or procedures, for example significant financial decisions being made at an inappropriate level in our organization;
- Inappropriate application of accounting principles or a significant failure of internal control over financial reporting, which could lead to a restatement of our results of operations and/or a deterioration in the soundness and accuracy of our reported results of operations; and
- Failure to adequately manage our run-off businesses and/or our regulatory and financial exposure to businesses we have sold, including Aetna's divested standalone Medicare Part D, domestic group life insurance, group disability insurance and absence management businesses.

Financial Risks

Goodwill and other intangible assets could, in the future, become impaired.

As of December 31, 2018, we had $115.2 billion of goodwill and other intangible assets. During the year ended December 31, 2018, we took $6.1 billion of goodwill impairment charges related to our LTC reporting unit. Goodwill and indefinitely-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable. When evaluating goodwill for potential impairment, we compare the fair value of our reporting units to their respective carrying amounts. We estimate the fair value of our reporting units using a combination of a discounted cash flow method and a market multiple method. If the carrying amount of a reporting unit exceeds its estimated fair value, a goodwill impairment loss is recognized in an amount equal to the excess to the extent of the goodwill balance. Estimated fair values could change if, for example, there are changes in the business climate, changes in the competitive environment, adverse legal or regulatory actions or developments, changes in capital structure, cost of debt, interest rates, capital expenditure levels, operating cash flows or market capitalization. Because of the significance of our goodwill and intangible assets, any future impairment of these assets could require material noncash charges to our results of operations, which could have a material adverse effect on our financial condition and results of operations.

We would be adversely affected if we do not effectively deploy our capital. Downgrades or potential downgrades in our credit ratings, should they occur, could adversely affect our brand and reputation, businesses, cash flows, financial condition and results of operations.

Our operations generate significant capital, and we have the ability to raise additional capital. The manner in which we deploy our capital, including investments in our businesses, our operations (such as information technology and

other strategic and capital projects), dividends, acquisitions, share and/or debt repurchases, repayment of debt, reinsurance or other capital uses, impacts our financial strength, claims paying ability and credit ratings issued by recognized rating organizations. Credit ratings issued by nationally-recognized organizations are broadly distributed and generally used throughout our industries. Our ratings reflect each rating organization's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to our insureds. We believe our credit ratings and the financial strength and claims paying ability of

our principal insurance and HMO subsidiaries are important factors in marketing our Health Care Benefits products to certain of our customers.

Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future. In connection with the completion of the Aetna Acquisition, each of Standard & Poor's, Moody's and Fitch downgraded certain of our debt, financial strength and/or other credit ratings. Downgrades in our ratings could adversely affect our businesses, cash flows, financial condition and results of operations.

Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative investments and other investments, our results of operations and/or our financial condition.

The global capital markets, including credit markets, continue to experience volatility and uncertainty. As an insurer, we have a substantial investment portfolio that supports our policy liabilities and surplus and is comprised largely of debt securities of issuers located in the United States. As a result, the income we earn from our investment portfolio is largely driven by the level of interest rates in the United States, and to a lesser extent the international financial markets; and volatility, uncertainty and/or disruptions in the global capital markets, particularly the United States credit markets, and governments' monetary policy, particularly United States monetary policy, can significantly and adversely affect the value of our investment portfolio, our results of operations and/or our financial condition by:

- Significantly reducing the value and/or liquidity of the debt securities we hold in our investment portfolio and creating realized capital losses that reduce our results of operations and/or unrealized capital losses that reduce our shareholders' equity;
- Keeping interest rates low on high-quality short-term or medium-term debt securities (such as we have experienced during recent years) and thereby materially reducing our net investment income and results of operations as the proceeds from securities in our investment portfolio that mature or are otherwise disposed of continue to be reinvested in lower yielding securities;
- Reducing the fair values of our investments if interest rates rise;
- Causing non-performance or defaults on their obligations to us by third parties, including customers, issuers of securities in our investment portfolio, mortgage borrowers and/or reinsurance and/or derivatives counterparties;
- Making it more difficult to value certain of our investment securities, for example if trading becomes less frequent, which could lead to significant period-to-period changes in our estimates of the fair values of those securities and cause period-to-period volatility in our net income and shareholders' equity;
- Reducing our ability to issue short-term debt securities at attractive interest rates, thereby increasing our interest expense and decreasing our results of operations; and
- Reducing our ability to issue other securities.

Although we seek, within guidelines we deem appropriate, to match the duration of our assets and liabilities and to manage our credit and counterparty exposures, a failure adequately to do so could adversely affect our net income and our financial condition and, in extreme circumstances, our cash flows.

Risks Relating to Our Acquisition of Aetna

We have limited experience in the insurance and managed health care industry, which may hinder our ability to achieve our objectives as a combined company.

We have limited experience operating an insurance and managed health care business, and are relying in large part on the existing management of Aetna to continue to manage our Health Care Benefits business. However, there is no assurance that we will be able to continue to retain the services of such management. If we fail to retain the existing management of Aetna, our ability to realize the anticipated benefits of the transaction may be adversely affected.

The Aetna Acquisition may not be accretive, and may be dilutive, to our earnings per share, which may adversely affect our stock price.

Although we currently project that the Aetna Acquisition will result in a number of benefits, including that it will be accretive to our earnings per share, changes in the estimates we use for these projections and the impact of future events and conditions, some of which we do not control, could cause actual results to be lower than these projections. In addition, future events and

conditions could decrease or delay the accretion that is currently projected or could result in dilution. These events and conditions include adverse changes in market conditions, changes in the regulatory environment, additional transaction and integration-related costs and other factors such as the failure to realize some or all of the anticipated benefits of the Aetna Acquisition. Any dilution of, decrease in or delay of any accretion to, our earnings per share could cause our stock price to decline or grow at a reduced rate.

We may fail to successfully combine the businesses and operations of CVS Health and Aetna to realize the anticipated benefits and cost savings of the Aetna Acquisition within the anticipated timeframe or at all, which could adversely affect our stock price.

The success of the Aetna Acquisition will depend, in part, on our ability to realize the anticipated benefits and cost savings from combining the businesses of CVS Health and Aetna. Our ability to realize these anticipated benefits and cost savings is subject to certain risks, including:

- Our ability to successfully combine the businesses of CVS Health and Aetna;
- whether the combined businesses will perform as expected;
- the possibility that we paid more for Aetna than the value we will derive from the acquisition;
- the reduction of our cash available for operations and other uses and the incurrence of indebtedness to finance the acquisition; and
- the assumption of known and unknown liabilities of Aetna.

If we are not able to successfully combine the businesses of CVS Health and Aetna within the anticipated time frame, the anticipated cost savings and other benefits of the Aetna Acquisition may not be realized fully or may take longer to realize than expected, the combined businesses may not perform as expected, and our stock price may be adversely affected.

Until the completion of the Aetna Acquisition, we and Aetna operated independently, and there can be no assurances that our respective businesses can be integrated successfully. It is possible that the integration process could result in the loss of key CVS Health or Aetna employees, the disruption of either company's or both companies' ongoing businesses or in unexpected integration issues, higher than expected integration costs and an overall post-completion integration process that takes longer than originally anticipated. Specifically, issues that must be addressed in integrating the operations of CVS Health and Aetna in order to realize the anticipated benefits of the Aetna Acquisition so the combined business performs as expected include, among other things:

- combining the companies' separate operational, financial, reporting and corporate functions;
- integrating the companies' technologies, products and services;
- identifying and eliminating redundant and underperforming operations and assets;
- harmonizing the companies' operating practices, employee development, compensation and benefit programs, internal controls and other policies, procedures and processes;
- addressing possible differences in business backgrounds, corporate cultures and management philosophies;
- consolidating the companies' corporate, administrative and information technology infrastructure;
- coordinating sales, distribution and marketing efforts;
- managing the movement of certain businesses and positions to different locations;
- maintaining existing agreements with customers, providers and vendors and avoiding delays in entering into new agreements with prospective customers, providers and vendors;

- operating in industry sectors in which we and our current management may have little or no experience;
- coordinating geographically dispersed organizations;
- consolidating offices of CVS Health and Aetna that are currently in or near the same location; and
- effecting the actions that are required by regulatory approvals we obtained in connection with completing the Aetna Acquisition.

In addition, at times, the attention of certain members of our management and our resources will be focused on the integration of the businesses of the two companies and diverted from day-to-day business operations, which may adversely affect our businesses.

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

Following completion of the Aetna Acquisition our business is significantly larger than the size of either CVS Health's or Aetna's respective pre-transaction businesses. The combined company's ability to successfully manage this expanded business will depend, in part, upon management's ability to implement an effective integration of the two companies and its ability to manage a combined business with significantly larger size and scope with the associated increased costs and complexity. There can be no assurances that the management of the combined company will be successful or that the combined company will realize the expected operating efficiencies, cost savings and other benefits currently anticipated from the Aetna Acquisition. If we are not able to fully realize the expected operating efficiencies, cost savings and other benefits anticipated from the Aetna Acquisition, or such benefits take longer to realize than expected, our combined businesses may not perform as expected and our stock price may be adversely affected.

We may have difficulty attracting, motivating and retaining executives and other key employees following completion of the Aetna Acquisition.

Our future success will depend in part on our ability to retain key executives and other employees of Aetna. Uncertainty about the effect of the Aetna Acquisition on CVS Health and Aetna employees may have an adverse effect on the combined company and consequently the combined business. This uncertainty may impair our ability to attract, retain and motivate key personnel. Employee retention may be particularly challenging during the integration process, as employees of CVS Health and Aetna may experience uncertainty about their future roles in the combined business.

Furthermore, if key employees of CVS Health or Aetna depart or are at risk of departing, including because of issues relating to the uncertainty and difficulty of integration, financial security or a desire not to remain as employees of the combined business, we may have to incur significant costs in retaining such individuals or in identifying, hiring and retaining replacements for departing employees and may lose significant expertise and talent relating to the business of Aetna, and our ability to realize the anticipated benefits of the Aetna Acquisition may be materially and adversely affected. Accordingly, no assurance can be given that we will be able to attract or retain key employees of Aetna to the same extent that Aetna was able to attract or retain employees in the past.

The Aetna integration process could disrupt our ongoing businesses and/or operations.

Parties with which we do business may experience uncertainty associated with the Aetna Acquisition and/or the post-closing integration process, including with respect to current or future business relationships with the combined business. Our business relationships (including business relationships of our Health Care Benefits segment) may be subject to disruption as customers, members, manufacturers, providers, vendors and others may attempt to negotiate changes in existing business relationships or consider entering into business relationships with parties other than the combined business. These disruptions could have a material adverse effect on the businesses, financial condition, results of operations or prospects of one or more of the combined company's businesses, including a material adverse effect on our ability to realize the anticipated benefits of the Aetna Acquisition.

Our indebtedness following completion of the Aetna Acquisition is substantially greater than our indebtedness on a stand-alone basis and greater than the combined indebtedness of CVS Health and Aetna existing prior to the announcement of the transaction. This increased level of indebtedness could adversely affect our business flexibility and increase our borrowing costs.

In order to complete the Aetna Acquisition, we incurred acquisition-related debt financing of approximately $45.0 billion and assumed Aetna's existing indebtedness with a fair value of approximately $8.1 billion. Our substantially increased indebtedness and higher debt-to-equity ratio following completion of the Aetna Acquisition in comparison to that of CVS Health prior to the Aetna Acquisition has the effect, among other things, of reducing our flexibility to respond to changing business and economic conditions and increases our interest expense compared to pre Aetna Acquisition periods. In addition, the amount of cash required to service our increased indebtedness levels and thus the demands on our cash resources are greater than the amount of cash flows required to service the indebtedness of CVS Health or Aetna individually prior to the Aetna Acquisition. The increased levels of indebtedness could also reduce funds available to fund our efforts to combine our business with Aetna and realize expected benefits of the Aetna Acquisition and/or engage in investments in product development, capital

expenditures, dividend payments, share repurchases and other activities and may create competitive disadvantages for us relative to other companies with lower debt levels.

We will continue to incur significant integration-related costs in connection with the Aetna Acquisition.

We expect to continue to incur significant non-recurring costs associated with combining the operations of CVS Health and Aetna. We expect to continue to incur significant integration-related costs related to formulating and implementing integration plans, including facilities and systems consolidation costs and employment-related costs. We continue to assess the magnitude of these costs, and additional unanticipated costs may be incurred in the integration of the two companies' businesses. We may not achieve the net benefit of such expenditures that we project associated with the elimination of duplicative costs, as well as the realization of other efficiencies related to the integration of our businesses in the near term, or at all. If we fail to realize the expected expense and other efficiencies we project, our results of operations, cash flows and stock price may be adversely affected.

Risks Related to Our Acquisitions, Joint Ventures and International Operations

We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities, which may be unsuccessful, cause us to assume unanticipated liabilities, disrupt our existing businesses, be dilutive or lead us to assume significant debt, among other things.

We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities as part of our growth strategy. In addition to integration risks, some other risks we face with respect to acquisitions and other inorganic growth strategies include:

- We frequently compete with other firms, some of which may have greater financial and other resources and a greater tolerance for risk, to acquire attractive companies;
- The acquired, alliance and/or joint venture businesses may not perform as projected;
- The goodwill or other intangible assets established as a result of our acquisitions may be incorrectly valued or may become non-recoverable;
- We may assume unanticipated liabilities, including those that were not disclosed to us or which we underestimated;
- The acquired businesses, or the pursuit of other inorganic growth strategies, could disrupt or compete with our existing businesses, distract management, result in the loss of key employees, divert resources, result in tax costs or inefficiencies and make it difficult to maintain our current business standards, controls, information technology systems, policies, procedures and performance;
- We may finance future acquisitions and other inorganic growth strategies by issuing common stock for some or all of the purchase price, which would dilute the ownership interests of our shareholders;
- We may incur significant debt in connection with acquisitions (whether to finance acquisitions or by assuming debt from the businesses we acquire);
- We may not have the expertise to manage and profitably grow the businesses we acquire, and we may need to rely on the retention of key personnel and other suppliers of businesses we acquire, which may be difficult or impossible to accomplish;
- We may enter into merger or purchase agreements but, due to reasons within or outside our control, fail to complete the related transactions, which could result in termination fees or other penalties that could be material, material disruptions to our businesses and operations and adversely affect our brand and reputation;
- In order to complete a proposed acquisition, we may be required to divest certain portions of our business;
- We may be involved in litigation related to mergers or acquisitions, including for matters which occurred prior to the applicable closing, which may be costly to defend and may result in adverse rulings against us that could be material; and
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- The integration into our businesses of the businesses and entities we acquire may affect the way in which existing laws and regulations apply to us, including subjecting us to laws and regulations that did not previously apply to us.

We expect joint ventures to be an important part of our business model transformation and inorganic growth strategies. Joint ventures present risks that are different from acquisitions, including selection of appropriate joint venture parties, initial and ongoing governance of the joint venture, joint venture compliance activities (including compliance with applicable CMS requirements), growing the joint venture's business in a manner acceptable to all the parties, including other providers in the networks that include joint ventures, maintaining positive relationships among the joint venture parties and the customers, and member and business disruption that may occur upon joint venture termination.

We may be unable to successfully integrate companies we acquire.

Upon the closing of any acquisition we complete, we will need to successfully integrate the products, services and related assets, as well as internal controls into our business operations. If an acquisition is consummated, the integration of the acquired business, its products, services and related assets into our company may also be complex and time-consuming and, if the integration is not fully successful, we may not achieve the anticipated benefits, operating and cost synergies or growth opportunities of an acquisition. Potential difficulties that may be encountered in the integration process include the following:

- Integrating personnel, operations and systems (including internal control environments and compliance policies), while maintaining focus on producing and delivering consistent, high quality products and services;
- Coordinating geographically dispersed organizations;
- Disruption of management's attention from our ongoing business operations;
- Retaining existing customers and attracting new customers; and
- Managing inefficiencies associated with integrating our operations.

An inability to realize the full extent of the anticipated benefits, operating and cost synergies, innovations and operations efficiencies or growth opportunities of an acquisition, as well as any delays or additional expenses encountered in the integration process, could have a material adverse effect on our businesses and results of operations. Furthermore, acquisitions, even if successfully integrated, may fail to further our business strategy as anticipated, expose us to increased competition or challenges with respect to our products, services or geographic markets, and expose us to additional liabilities associated with an acquired business including risks and liabilities associated with litigation involving the acquired business. Any one of these challenges or risks could impair our ability to realize any benefit from our acquisitions after we have expended resources on them.

As a result of our expanded international operations, we face political, legal and compliance, operational, regulatory, economic and other risks that we do not face or are more significant than in our domestic operations.

We significantly expanded our international operations as a result of the closing of the Aetna Acquisition in November 2018. As a result of our expanded international operations, we face political, legal, compliance, operational, regulatory, economic and other risks that we do not face or that are more significant than in our domestic operations. These risks vary widely by country and include varying regional and geopolitical business conditions and demands, government intervention and censorship, discriminatory regulation, nationalization or expropriation of assets and pricing constraints. Our international products need to meet country-specific customer and member preferences as well as country-specific legal requirements, including those related to licensing, privacy, data storage, location, protection and security.

Our international operations increase our exposure to, and require us to devote significant management resources to implement controls and systems to comply with, the privacy and data protection laws of non-U.S. jurisdictions and the anti-bribery, anti-corruption and anti-money laundering laws of the United States (including the FCPA) and the United Kingdom (including the UK Bribery Act) and similar laws in other jurisdictions. Implementing our compliance policies, internal controls and other systems upon our expansion into new countries and geographies may require the investment of considerable management time and management, financial and other resources over a number of years before any significant revenues or profits are generated. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or employees, restrictions or outright prohibitions on the conduct of our business, and significant brand and reputational harm. We must regularly reassess the size, capability and location of our global infrastructure and make appropriate changes, and must have effective change management processes and internal controls in place to address changes in our businesses and operations. Our success depends, in part, on our ability to anticipate these risks and manage these difficulties, and the failure to do so could have a material adverse effect on our businesses, results of operations, financial condition, brand, reputation and/or long-term growth.

Our international operations require us to overcome logistical and other challenges based on differing languages, cultures, legal and regulatory schemes and time zones. Our international operations encounter labor laws, standards

and customs that can be difficult and make employee relationships less flexible than in our domestic operations and expensive to modify or terminate. In some countries we are required to, or choose to, operate with local business associates, which requires us to manage our relationships with these third parties and may reduce our operational flexibility and ability to quickly respond to business challenges.

In some countries we may be exposed to currency exchange controls or other restrictions that prevent us from transferring funds internationally or converting local currencies into U.S. dollars or other currencies. Fluctuations in foreign currency exchange rates may adversely affect our revenues, results of operations and cash flows from our international operations. Some of our operations are, and are increasingly likely to be, in emerging markets where these risks are heightened. Any measures we may implement to reduce the effect of volatile currencies and other risks on our international operations may not be effective.

Item 1B. Unresolved Staff Comments

There are no unresolved SEC Staff Comments.

Item 2. Properties

The Company's principal office is an owned building complex located in Woonsocket, Rhode Island, which totals approximately one million square feet. In addition, the Company leases corporate offices in Arizona, Illinois, Ohio, Pennsylvania, Texas, and Brazil.

Pharmacy Services Segment

As of December 31, 2018, the Pharmacy Services segment had the following properties:

- An owned mail service dispensing pharmacy located in Texas;
- Leased mail order dispensing pharmacies located in Hawaii, Illinois and Pennsylvania;
- Leased call centers located in California, Missouri, Pennsylvania, Tennessee and Texas;
- Approximately 40 leased on-site pharmacy stores, approximately 25 leased retail specialty pharmacy stores, approximately 20 specialty mail order pharmacies and approximately 90 branches for infusion and enteral services.

Retail/LTC Segment

As of December 31, 2018, the Retail/LTC segment had the following properties:

- Approximately 8,200 retail stores, of which approximately 4% were owned. Net selling space for retail stores was approximately 80.5 million square feet as of December 31, 2018. Approximately 25% of the store base was opened or significantly remodeled within the last five years;
- Approximately 1,700 retail pharmacies and approximately 80 clinics in Target stores;
- Nine owned distribution centers located in eight states and 13 leased distribution facilities located in twelve additional states and Brazil. The 22 distribution centers totaled approximately 10.4 million square feet as of December 31, 2018; and
- Six owned LTC pharmacies, approximately 150 leased LTC pharmacies in 46 states and one owned LTC repackaging facility.

In connection with certain business dispositions completed between 1991 and 1997, the Company continues to guarantee lease obligations for approximately 85 former stores. The Company is indemnified for these guarantee obligations by the respective purchasers. These guarantees generally remain in effect for the initial lease term and any extension thereof pursuant to a renewal option provided for in the lease prior to the time of the disposition. For additional information on these guarantees, see "Lease Guarantees" in Note 16 "Commitments and Contingencies" contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

Health Care Benefits Segment

The Health Care Benefits segment's principal office is an owned building complex that is approximately 1.7 million square feet in size and is located in Hartford, Connecticut. The Health Care Benefits segment also owns or leases other space in the greater Hartford area, Maryland, Pennsylvania, and various field locations in the United States and several other countries.

Management believes that the Company's owned and leased facilities are suitable and adequate to meet the Company's anticipated needs. At the end of the existing lease terms, management believes the leases can be renewed or replaced by

alternative space. For additional information on the amount of rental obligations for the Company's leases, see Note 6 ''Leases'' contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

Item 3. Legal Proceedings

I. Legal Proceedings

The information contained in Note 16 ''Commitments and Contingencies'' of the "Notes to Consolidated Financial Statements" in the Annual Report is incorporated by reference herein.

II. Environmental Matters

Item 103 of SEC Regulation S-K requires disclosure of environmental legal proceedings with a governmental authority if management reasonably believes that the proceedings involve potential monetary sanctions of $100,000 or more. The Company is in the process of negotiating with the New York State Department of Environmental Conservation to resolve claims of alleged historical noncompliance with hazardous waste regulations in connection with LTC pharmacies in the State of New York. These proceedings are not material to the Company's business or financial condition.

Item 4. Mine Safety Disclosures

Not applicable.

PART II

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

Market information

The Company's common stock is listed on the New York Stock Exchange under the symbol "CVS."

Holders of common stock

The information under the heading "Holders of Common Stock" in the Annual Report is incorporated by reference herein.

Dividends

The quarterly cash dividend declared by the Company's Board of Directors (the "Board") was $0.50 per share in 2018 and 2017.

CVS Health has paid cash dividends every quarter since becoming a public company. Future dividends will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

Issuer purchases of equity securities

The following share repurchase programs were authorized by the Board:

In billions			**Remaining as of December 31, 2018**
Authorization Date	**Authorized**		
November 2, 2016 ("2016 Repurchase Program")	$	15.0	$ 13.9
December 15, 2014 ("2014 Repurchase Program")		10.0	—

The share Repurchase Programs, each of which was effective immediately, permit the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase transactions, and/or other derivative transactions. The 2016 Repurchase Program can be modified or terminated by the Board at any time. During the three months ended December 31, 2018 the Company did not repurchase any shares of common stock.

See Note 12 ''Shareholders' Equity'' of the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein, for additional information regarding the Company's share repurchases.

Item 6. Selected Financial Data

The selected consolidated financial data of CVS Health Corporation as of and for the periods indicated in the five-year period ended December 31, 2018, have been derived from the consolidated financial statements of CVS Health Corporation and is incorporated herein by reference to the information contained in the Annual Report under the heading "Five-Year Financial Summary." The selected consolidated financial data should be read in conjunction with the consolidated financial statements and the audit reports of Ernst & Young LLP, which are incorporated by reference elsewhere in this Annual Report on Form 10-K.

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

The information contained in "Management's Discussion and Analysis of Financial Condition and Results of Operations" in the Annual Report, which includes the "Cautionary Statement Concerning Forward-Looking Statements" at the end of such section, is incorporated by reference herein.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

The information contained in "Management's Discussion and Analysis of Financial Condition and Results of Operations — Quantitative and Qualitative Disclosures About Market Risk" in the Annual Report is incorporated by reference herein.

Item 8. Financial Statements and Supplementary Data

The information contained in "Consolidated Statements of Operations," "Consolidated Statements of Comprehensive Income (Loss)," "Consolidated Balance Sheets," "Consolidated Statements of Shareholders' Equity," "Consolidated Statements of Cash Flows," "Notes to Consolidated Financial Statements," and "Report of Independent Registered Public Accounting Firm" in the Annual Report, is incorporated by reference herein.

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

None.

Item 9A. Controls and Procedures

Evaluation of disclosure controls and procedures

The Company's Chief Executive Officer and Chief Financial Officer, after evaluating the effectiveness of the design and operation of the Company's disclosure controls and procedures (as defined in Rules 13a-15 (f) and 15d-15(f) under the Securities Exchange Act of 1934) as of December 31, 2018, have concluded that as of such date the Company's disclosure controls and procedures were adequate and effective at a reasonable assurance level and designed to ensure that material information relating to the Company and its consolidated subsidiaries would be made known to such officers on a timely basis.

Internal control over financial reporting

The "Management's Report on Internal Control Over Financial Reporting" and "Report of Independent Registered Public Accounting Firm" sections of the Annual Report are incorporated by reference herein. These sections contain management's report on the Company's internal control over financial reporting and the Independent Registered Public Accounting Firm's report with respect to the effectiveness the Company's internal control over financial reporting.

Changes in internal control over financial reporting

On November 28, 2018, the Company completed its acquisition of Aetna. In conducting its assessment of the effectiveness of the Company's internal control over financial reporting as of December 31, 2018, management has elected to exclude Aetna from that assessment, as permitted under SEC rules. The Company is in the process of integrating the historical internal control over financial reporting of Aetna with the rest of the Company. Aetna's operations are included in the Company's 2018 consolidated financial statements for the period from November 28,

2018 to December 31, 2018 and represented 21% of the Company's consolidated total assets as of December 31, 2018 and 3% of the Company's consolidated total revenues for the year ended December 31, 2018.

Other than the foregoing, there has been no change in the Company's internal control over financial reporting identified in connection with the evaluation required by paragraph (d) of Rule 13a-15 or Rule 15d-15 that occurred during the fourth quarter ended December 31, 2018 that has materially affected, or is reasonably likely to materially affect, the Company's internal control over financial reporting.

Item 9B. Other Information

No events have occurred during the fourth quarter ended December 31, 2018 that would require disclosure under this item.

PART III

Item 10. Directors, Executive Officers and Corporate Governance

The sections of the Proxy Statement under the captions "Committees of the Board," "Code of Conduct," "Audit Committee Report," "Biographies of our Incumbent Board Nominees," and "Section 16(a) Beneficial Ownership Reporting Compliance" are incorporated by reference herein.

Executive Officers of the Registrant

The following sets forth the name, age and biographical information for each of the Registrant's executive officers as of February 28, 2019. In each case the officer's term of office extends to the date of the board of directors meeting following the next annual meeting of stockholders of the Company. Previous positions and responsibilities held by each of the executive officers over the past five years or more are indicated below:

Lisa G. Bisaccia, age 62, Executive Vice President of CVS Health Corporation since March 2016 and Chief Human Resources Officer of CVS Health Corporation since January 2010; Senior Vice President of CVS Health Corporation from January 2010 through February 2016; Vice President, Human Resources of CVS Pharmacy, Inc. from September 2004 through December 2009. Ms. Bisaccia is also a member of the board of directors of Aramark, a leading global provider of food, facilities and uniform services.

Eva C. Boratto, age 52, Executive Vice President and Chief Financial Officer of CVS Health Corporation since November 2018; Executive Vice President - Controller and Chief Accounting Officer of CVS Health Corporation from March 2017 through November 2018; Senior Vice President - Controller and Chief Accounting Officer of CVS Health Corporation from July 2013 through February 2017; Senior Vice President of PBM Finance from July 2010 through June 2013.

Troyen A. Brennan, M.D., age 64, Executive Vice President and Chief Medical Officer of CVS Health Corporation since November 2008; Executive Vice President and Chief Medical Officer of Aetna Inc. from February 2006 through November 2008.

James D. Clark, age 54, Senior Vice President - Controller and Chief Accounting Officer of CVS Health Corporation since November 2018; Vice President - Finance and Accounting of CVS Pharmacy, Inc. from September 2009 through October 2018.

Joshua M. Flum, age 49, Executive Vice President, Enterprise Strategy and Digital since November 2018; Executive Vice President, Corporate Strategy and Business Development of CVS Pharmacy, Inc. from June 2016 through October 2018; Executive Vice President - Pharmacy Services of CVS Pharmacy, Inc. from March 2015 through May 2016; Senior Vice President of Retail Pharmacy of CVS Pharmacy, Inc. from December 2010 through February 2015. Mr. Flum is a member of the board of directors of CreditRiskMonitor.com, Inc., a company that facilitates the analysis of corporate financial risk, mostly in the context of the extension of trade credit from one business to another.

Kevin P. Hourican, age 45, Executive Vice President of CVS Health Corporation and President of CVS Pharmacy since April 2018; Executive Vice President - Retail Pharmacy and Supply Chain of CVS Pharmacy, Inc. from June 2016 through March 2018; Senior Vice President, Field Operations and Supply Chain of CVS Pharmacy, Inc. from June 2014 through May 2016; Senior Vice President, Field Operations of CVS Pharmacy, Inc. from June 2012 through May 2014.

Alan M. Lotvin, M.D., age 57, Executive Vice President - Transformation of CVS Health Corporation since June 2018; Executive Vice President - Specialty Pharmacy, CVS Caremark from November 2012 through May 2018.

Karen S. Lynch, age 56, Executive Vice President of CVS Health Corporation and President of Aetna since November 2018; President of Aetna from January 2015 to the present; Executive Vice President, Local and Regional Businesses of Aetna from February 2013 through December 2014; Executive Vice President, Head of Specialty Products of Aetna from July 2012 through January 2013. Ms. Lynch is a member of the board of directors of U.S. Bancorp, a banking and financial services company.

Larry J. Merlo, age 63, President and Chief Executive Officer of CVS Health Corporation since March 2011; President and Chief Operating Officer of CVS Health Corporation from May 2010 through March 2011; President of CVS Pharmacy from January 2007 through August 2011; Executive Vice President of CVS Health Corporation from January 2007 through May 2010; also a director of CVS Health Corporation since May 2010.

Thomas M. Moriarty, age 55, Executive Vice President and General Counsel of CVS Health Corporation since October 2012 and Chief Policy and External Affairs Officer since March 2017; Chief Strategy Officer from March 2014 through February 2017.

Derica W. Rice, age 54, Executive Vice President of CVS Health Corporation and President of CVS Caremark since March 2018; Executive Vice President of Global Services and Chief Financial Officer of Eli Lilly & Co. from May 2006 through December 2017. Mr. Rice was formerly a director of Target Corporation from September 2007 until January 2018, and is a candidate for election to the board of directors of The Walt Disney Company in March 2019.

Jonathan C. Roberts, age 63, Executive Vice President and Chief Operating Officer of CVS Health Corporation since March 2017; Executive Vice President of CVS Health Corporation and President of CVS Caremark from September 2012 through February 2017; Executive Vice President of CVS Health Corporation and Chief Operating Officer of CVS Caremark from October 2010 through August 2011.

Item 11. Executive Compensation

The sections of the Proxy Statement under the captions “Non-Employee Director Compensation” and “Executive Compensation and Related Matters,” including “Compensation Discussion and Analysis,” “Letter from the Management Planning and Development Committee,” “Compensation Committee Report” and “Executive Compensation Tables” are incorporated by reference herein.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

The sections of the Proxy Statement under the captions “Share Ownership of Directors and Certain Executive Officers” and “Share Ownership of Principal Stockholders” are incorporated by reference herein. Those sections contain information concerning security ownership of certain beneficial owners and management and related stockholder matters.

The following table summarizes information about the Company’s common stock that may be issued upon the exercise of options, warrants and rights under all of equity compensation plans as of December 31, 2018.

	Number of securities to be issued upon exercise of outstanding options, warrants and rights [1][2] (a)	Weighted average exercise price of outstanding options, warrants and rights (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in first column) [1] (c)
Equity compensation plans approved by stockholders [3]	27,102	$ 77.51	25,927
Equity compensation plans not approved by stockholders [4][5]	5,136	43.01	31,633

Total	32,238	$ 75.04	57,560

(1) Shares in thousands.

(2) Consists of: (i) 18,597 shares of common stock underlying outstanding options, (ii) 1,435 shares of common stock issuable upon the exercise of outstanding stock appreciation rights ("SARs") and (iii) 12,206 shares of common stock issuable on the vesting of outstanding restricted stock units, deferred stock units and performance stock units, assuming target level performance in the case of performance stock units. The number of shares included with respect to

outstanding SARs is the number of shares of the Company's common stock that would have been issued had the SARs been exercised based on the closing price per share of the Company's common stock on December 31, 2018, as reported on the NYSE, which was $65.52.

(3) Consists of the CVS Health 2017 Incentive Compensation Plan.

(4) Consists of the Amended Aetna Inc. 2010 Stock Incentive Plan (the "Aetna Stock Plan").

(5) Amount in column (c) consists of the maximum number of shares of the Company's common stock available for future issuance under the Aetna Stock Plan as of December 31, 2018.

The Aetna Stock Plan was last approved by Aetna's shareholders at Aetna's 2017 Annual Meeting on May 19, 2017. The Company elected to continue to grant awards under the Aetna Stock Plan to employees of Aetna and its subsidiaries following the completion of the Aetna Acquisition. The Aetna Stock Plan is designed to promote the Company's interests and those of its stockholders and to further align the interests of stockholders and employees by tying awards to total return to stockholders, enabling plan participants to acquire additional equity interests in the Company and providing compensation opportunities dependent upon the Company's performance. The Aetna Stock Plan has not been submitted to the Company's stockholders and will expire on May 21, 2020.

Under the Aetna Stock Plan, eligible participants can be granted stock options to purchase shares of the Company's common stock, SARs, time vesting and/or performance vesting incentive stock or incentive units and other stock based awards. As of December 31, 2018, the maximum number of shares of the Company's common stock that may be issued under the awards outstanding under the Aetna Stock Plan was 5.1 million shares, subject to adjustment for corporate transactions and 31.6 million shares remained available for future awards. If an award under the Aetna Stock Plan is paid solely in cash, no shares are deducted from the number of shares available for issuance under the Aetna Stock Plan.

Item 13. Certain Relationships and Related Transactions, and Director Independence

The sections of the Proxy Statement under the captions "Independence Determinations for Directors" and "Related Person Transaction Policy" are incorporated by reference herein.

Item 14. Principal Accounting Fees and Services

The section of the Proxy Statement under the caption "Item 2: Ratification of Appointment of Independent Registered Public Accounting Firm" is incorporated by reference herein.

PART IV

Item 15. Exhibits, Financial Statement Schedules

The following documents are filed as part of this Annual Report on Form 10-K:

1. Financial Statements. The following financial statements, related notes and report are incorporated by reference from the Annual Report in Item 8 hereof:

Consolidated Statements of Operations for the Years Ended December 31, 2018, 2017 and 2016
Consolidated Statements of Comprehensive Income (Loss) for the Years Ended December 31, 2018, 2017 and 2016
Consolidated Balance Sheets as of December 31, 2018 and 2017
Consolidated Statements of Cash Flows for the Years Ended December 31, 2018, 2017 and 2016
Consolidated Statements of Shareholders' Equity for the Years Ended December 31, 2018, 2017 and 2016
Notes to Consolidated Financial Statements
Report of Independent Registered Public Accounting Firm

2. Financial Statement Schedules. All financial statement schedules are omitted because they are not applicable, not required under the instructions, or the information is included in the consolidated financial statements or related notes.

3. Exhibits. The exhibits listed in the "Index to Exhibits" in this Item 15 are filed or incorporated by reference as part of this Annual Report on Form 10-K. Exhibits marked with an asterisk (*) are management contracts or compensatory plans or arrangements. Exhibits other than those listed are omitted because they are not required to be listed or are not applicable. Pursuant to Item 601(b)(4)(iii) of Regulation S-K, the Registrant hereby agrees to furnish to the Securities and Exchange Commission a copy of any omitted instrument that is not required to be listed.

INDEX TO EXHIBITS

Exhibit	Description
2	**Plan of acquisition, reorganization, arrangement, liquidation or succession**
2.1	Agreement and Plan of Merger, dated as of May 20, 2015, among CVS Pharmacy, Inc., Tree Merger Sub, Inc. and Omnicare, Inc. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K filed May 21, 2015; Commission File No. 001-01011).
2.2	Agreement and Plan of Merger, dated as of December 3, 2017, among CVS Health Corporation, Hudson Merger Sub Corp. and Aetna Inc. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K filed December 5, 2017; Commission File No. 001-01011).
2.3	Master Transaction Agreement by and between Aetna Inc. and Hartford Life and Accident Insurance Company dated as of October 22, 2017.
3	**Articles of Incorporation and Bylaws**
3.1	Restated Certificate of Incorporation of the Registrant (incorporated by reference to Exhibit 3.1C of Registrant's Current Report on Form 8-K filed June 5, 2018; Commission File No. 001-01011).
3.2	By-laws of the Registrant, as amended and restated (incorporated by reference to Exhibit 3.2 to the Registrant's Current Report on Form 8-K filed June 5, 2018; Commission File No. 001-01011).
4	**Instruments defining the rights of security holders, including indentures**
4.1	Specimen common stock certificate (incorporated by reference to Exhibit 4.1 to the Registration Statement of the Registrant ((then known as CVS Corporation) as successor to Melville Corporation) on Form 8-B filed November 4, 1996; Commission File No. 001-01011).
4.2	Senior Indenture dated August 15, 2006, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed August 15, 2006; Commission File No. 001-01011).
4.3	

	Form of the Registrant's 2020 Floating Rate Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.4	Form of the Registrant's 2021 Floating Rate Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).

4.5	Form of the Registrant's 2020 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.6	Form of the Registrant's 2021 Note (incorporated by reference to Exhibit 4.4 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.7	Form of the Registrant's 2023 Note (incorporated by reference to Exhibit 4.5 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.8	Form of the Registrant's 2025 Note (incorporated by reference to Exhibit 4.6 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.9	Form of the Registrant's 2028 Note (incorporated by reference to Exhibit 4.7 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.10	Form of the Registrant's 2038 Note (incorporated by reference to Exhibit 4.8 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.11	Form of the Registrant's 2048 Note (incorporated by reference to Exhibit 4.9 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
10	**Material Contracts**
10.1	Credit Agreement dated as of July 1, 2015, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2015 (Commission File No. 001-01011).
10.2	Amendment No. 1 to Credit Agreement dated as of December 15, 2017, to the Credit Agreement dated as of July 1, 2015, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.5 to the Registrant's Current Report on Form 8-K filed December 19, 2017; Commission File No. 001-01-011).
10.3	Amendment No. 2 to Credit Agreement dated as of May 17, 2018, to the Credit Agreement dated as of July 1, 2015, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.3 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01-011).
10.4	Five Year Credit Agreement, dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011).
10.5	Amendment No. 1 to Five Year Credit Agreement dated as of December 15, 2017, to the Five Year Credit Agreement dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.3 to the Registrant's Current Report on Form 8-K filed December 19, 2017; Commission File No. 001-01011).
10.6	Amendment No. 2 to Five Year Credit Agreement dated as of May 17, 2018, to the Five Year Credit Agreement dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01011).
10.7	Term Loan Agreement dated as of December 15, 2017, by and among the Registrant, the lenders party thereto and Barclays Bank PLC, as administrative agent (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed December 19, 2017; Commission File No. 001-01011).
10.8	Amendment No. 1 to Term Loan Agreement dated as of May 17, 2018, to the Term Loan Agreement dated as of December 15, 2017, by and among the Registrant, the lenders party thereto and Barclays Bank PLC, as Administrative Agent (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01011).
10.9	364-Day Credit Agreement dated as of May 17, 2018, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01011).
10.10	Five Year Credit Agreement dated as of May 17, 2018, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to

	Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01011).
10.11	Bridge Facility Commitment Letter dated December 3, 2017, by and among the Registrant, Barclays Bank PLC, Goldman Sachs Bank USA, Goldman Sachs Lending Partners LLC, Bank of America, N.A., and Merrill Lynch, Pierce Fenner & Smith Incorporated (incorporated by reference to Exhibit 2.2 to the Registrant's Current Report on Form 8-K filed December 5, 2017; Commission File No. 001-01011).

10.12	Joinder to Bridge Facility Commitment Letter dated as of December 15, 2017, by and among the Registrant, Barclays Bank PLC, Goldman Sachs Bank USA, Goldman Sachs Lending Partners LLC, Bank of America, N.A., Merrill Lynch, Pierce, Fenner & Smith Incorporated, and each of the Additional Commitment Parties party thereto (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K filed December 19, 2017; Commission File No. 001-01011).
10.13	364-Day Bridge Term Loan Agreement, dated October 26, 2018, by and among the Registrant, the lenders party thereto and Barclays Bank PLC, as Administrative Agent (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed October 26, 2018; Commission File No. 001-010011).
10.14*	The Registrant's 1996 Directors Stock Plan, as amended and restated November 5, 2002 (incorporated by reference to Exhibit 10.18 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 28, 2002; Commission File No. 001-01011).
10.15*	Caremark Rx, Inc. 2004 Incentive Stock Plan (incorporated by reference to Exhibit 99.2 of the Registrant's Registration Statement No. 333-141481 on Form S-8 filed March 22, 2007; Commission File No. 011-01011).
10.16*	The Registrant's Supplemental Retirement Plan I for Select Senior Management, as amended and restated as of December 31, 2008 (incorporated by reference to Exhibit 10.6 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2009; Commission File No. 011-01011).
10.17*	The Registrant's 1997 Incentive Compensation Plan, as amended through December 31, 2008 (incorporated by reference to Exhibit 10.8 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2009; Commission File No. 011-01011).
10.18*	Form of Enterprise Non-Competition, Non-Disclosure and Developments Agreement between the Registrant and certain of the Registrant's executive officers (incorporated by reference to Exhibit 10.25 of the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013; Commission File No. 001-01011).
10.19*	The Registrant's 2010 Incentive Compensation Plan, as amended through January 15, 2013 (incorporated by reference to Exhibit A to the Registrant's Definitive Proxy Statement on Form 14A filed March 27, 2015; Commission File No. 001-01011).
10.20*	The Registrant's Deferred Stock Compensation Plan, as amended (incorporated by reference to Exhibit 10.17 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011).
10.21*	The Registrant's 2007 Employee Stock Purchase Plan, as amended (incorporated by reference to Exhibit 10.20 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011).
10.22*	Universal 409A Definition Document, as amended (incorporated by reference to Exhibit 10.28 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011).
10.23*	The Registrant's Deferred Compensation Plan, as amended (incorporated by reference to Exhibit 10.19 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.24*	The Registrant's Partnership Equity Program, as amended (incorporated by reference to Exhibit 10.25 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.25*	The Registrant's Performance-Based Restricted Stock Unit Plan, as amended (incorporated by reference to Exhibit 10.27 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.26*	The Registrant's 2017 Incentive Compensation Plan (incorporated by reference to Exhibit A to the Registrant's Definitive Proxy Statement on Form 14A filed March 31, 2017; Commission File No. 001-01011).
10.27*	The Registrant's Executive Incentive Plan, as amended (incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011).
10.28*	The Registrant's Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011).
10.29*	

	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.29 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.30*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.30 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).

10.31*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.32*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax) (incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.33*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Post-Tax) (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.34*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018; Commission File No. 001-01011).
10.35*	Form of Performance Stock Unit Agreement (LTIP) - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018; Commission File No. 001-01011).
10.36*	The Registrant's 2018 Management Incentive Plan.
10.37*	The Registrant's Severance Plan for Non-Store Employees amended as of November 28, 2018.
10.38*	The Registrant's Performance-Based Restricted Stock Unit Program, as amended.
10.39*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant.
10.40*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant.
10.41*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant.
10.42*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax).
10.43*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Post-Tax) (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013; Commission File No. 001-01011).
10.44*	Amended Aetna Inc. 2010 Stock Incentive Plan, as amended May 19, 2017 (incorporated by reference to Exhibit 99.1 to the Registrant's Registration Statement on Form S-8 filed November 30, 2018; Commission File No. 001-01011).
10.45*	Form of Aetna Inc. 2010 Stock Incentive Plan - Market Stock Unit Terms of Award.
10.46*	Form of Aetna Inc. 2010 Stock Incentive Plan - Performance Stock Unit Terms of Award (2015).
10.47*	Form of Aetna Inc. 2010 Stock Incentive Plan - Executive Restricted Stock Unit Terms of Award (2015).
10.48*	Form of Aetna Inc. 2010 Stock Incentive Plan - Stock Appreciation Right Terms of Award (2015).
10.49*	Amended and Restated Employment Agreement dated as of December 21, 2012 between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.50*	Form of Non-Qualified Stock Option Agreement - Annual Grant between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.37 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.51*	Form of Restricted Stock Unit Agreement - Annual Grant between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.52*	Amendment dated January 22, 2015 to Nonqualified Stock Option Agreements between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed January 23, 2015; Commission File No. 001-01011).
10.53*	Change in Control Agreement dated December 22, 2008 between the Registrant and David Denton (incorporated by reference to Exhibit 10.39 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2010; Commission File No. 001-01011).

10.54*	Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and David Denton (incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.55*	Confidential Separation Agreement effective as of June 25, 2018, between the Registrant and David Denton (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended September 30, 2018; Commission File No. 001-01011).

10.56*	Change in Control Agreement dated December 22, 2008 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.57*	Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.34 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.58*	Restricted Stock Unit Agreement - Annual Grant dated April 1, 2016 between the Registrant and Jonathan C. Roberts (incorporated by reference to Exhibit 10.44 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.59*	Restrictive Covenant Agreement dated May 20, 2016 between the Registrant and Jonathan C. Roberts (incorporated by reference to Exhibit 10.45 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.60*	Change in Control Agreement dated December 22, 2008 between the Registrant and Helena Foulkes (incorporated by reference to Exhibit 10.43 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.61*	Amendment dated as of December 31, 2012 to the Change in Control Agreement between the Registrant and Helena Foulkes (incorporated by reference to Exhibit 10.44 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.62*	Change in Control Agreement dated October 1, 2012 between the Registrant and Thomas Moriarity (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2015; Commission File No. 001-01011).
10.63*	Restrictive Covenant Agreement dated June 1, 2014 between the Registrant and Thomas Moriarity (incorporated by reference to Exhibit 10.2 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2015; Commission File No. 001-01011).
13	**Annual Report to security holders, Form 10-Q or quarterly report to security holders**
13.1	Portions of the 2018 Annual Report to Stockholders of CVS Health Corporation, which are specifically designated in this Annual Report on Form 10-K as being incorporated by reference.
21	**Subsidiaries of the registrant**
21.1	Subsidiaries of CVS Health Corporation.
23	**Consents of experts and counsel**
23.1	Consent of Ernst & Young LLP.
31	**Rule 13a-14(a)/15d-14(a) Certifications**
31.1	Certification by the Chief Executive Officer.
31.2	Certification by the Chief Financial Officer.
32	**Section 1350 Certifications**
32.1	Certification by the Chief Executive Officer.
32.2	Certification by the Chief Financial Officer.
101	**Interactive Data File**
101	The following materials from the CVS Health Corporation Annual Report on Form 10-K for the fiscal year ended December 31, 2018 formatted in Extensible Business Reporting Language (XBRL): (i) the Consolidated Statements of Operations, (ii) the Consolidated Statements of Comprehensive Income, (iii) the Consolidated Balance Sheets, (iv) the Consolidated Statements of Cash Flows, (v) the Consolidated Statements of Shareholders' Equity and (vi) the related Notes to Consolidated Financial Statements.

Item 16. Form 10-K Summary

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

CVS HEALTH CORPORATION

Date: February 28, 2019 By: /s/ EVA C. BORATTO

Eva C. Boratto

Executive Vice President and Chief Financial Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title(s)	Date
/s/ FERNANDO AGUIRRE **Fernando Aguirre**	Director	February 28, 2019
/s/ MARK T. BERTOLINI **Mark T. Bertolini**	Director	February 28, 2019
/s/ RICHARD M. BRACKEN **Richard M. Bracken**	Director	February 28, 2019
/s/ C. DAVID BROWN II **C. David Brown II**	Director	February 28, 2019
/s/ EVA C. BORATTO **Eva C. Boratto**	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 28, 2019
/s/ JAMES D. CLARK **James D. Clark**	Senior Vice President - Controller and Chief Accounting Officer (Principal Accounting Officer)	February 28, 2019
/s/ ALECIA A. DECOUDREAUX **Alecia A. DeCoudreaux**	Director	February 28, 2019
/s/ NANCY-ANN M. DEPARLE **Nancy-Ann M. DeParle**	Director	February 28, 2019
/s/ DAVID W. DORMAN **David W. Dorman**	Chair of the Board and Director	February 28, 2019
/s/ ROGER N. FARAH **Roger N. Farah**	Director	February 28, 2019
/s/ ANNE M. FINUCANE **Anne M. Finucane**	Director	February 28, 2019
/s/ EDWARD J. LUDWIG **Edward J. Ludwig**	Director	February 28, 2019
/s/ LARRY J. MERLO **Larry J. Merlo**	President and Chief Executive Officer (Principal Executive Officer) and Director	February 28, 2019
/s/ JEAN-PIERRE MILLON **Jean-Pierre Millon**	Director	February 28, 2019
/s/ MARY L. SCHAPIRO **Mary L. Schapiro**	Director	February 28, 2019
/s/ RICHARD J. SWIFT	Director	February 28, 2019

Richard J. Swift		
/s/ WILLIAM C. WELDON	Director	February 28, 2019
William C. Weldon		
/s/ TONY L. WHITE	Director	February 28, 2019
Tony L. White		

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

☒ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

For the fiscal year ended December 31, 2017

OR

☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

For the transition period from to

Commission file number 001-01011

Image - Image1.gif

CVS HEALTH CORPORATION
(Exact name of Registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

(401) 765-1500
(Registrant's telephone number, including area code)

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

Common Stock, par value $0.01 per share	**New York Stock Exchange**
Title of each class	Name of each exchange on which registered

Securities registered pursuant to Section 12(g) of the Exchange Act:
None

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

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

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

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

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

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐
	Emerging growth company ☐

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

The aggregate market value of the registrant's common stock held by non-affiliates was approximately $81,440,458,676 as of June 30, 2017, based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be the affiliates of the registrant.

As of February 9, 2018, the registrant had 1,014,532,157 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Filings made by companies with the Securities and Exchange Commission sometimes "incorporate information by reference." This means that the company is referring you to information that was previously filed or is to be filed with the SEC, and this information is considered to be part of the filing you are reading. The following materials are incorporated by reference into this Form 10-K:

Portions of our Annual Report to Stockholders for the fiscal year ended December 31, 2017 are incorporated by reference in our response to Items 7, 8 and 9 of Part II.

Information contained in our Proxy Statement for the 2018 Annual Meeting of Stockholders is incorporated by reference in our response to Items 10 through 14 of Part III.

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PART I

Item 1. Business

Overview

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is a pharmacy innovation company helping people on their path to better health. At the forefront of a changing health care landscape, the Company has an unmatched suite of capabilities and the expertise needed to drive innovations that will help shape the future of health care.

We are currently the only integrated pharmacy health care company with the ability to impact consumers, payors, and providers with innovative, channel-agnostic solutions. We have a deep understanding of their diverse needs through our unique integrated model, and we are bringing them innovative solutions that help increase access to quality care, deliver better health outcomes and lower overall health care costs.

Through more than 9,800 retail locations, more than 1,100 walk-in health care clinics, a leading pharmacy benefits manager with more than 94 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year, expanding specialty pharmacy services and a leading stand-alone Medicare Part D prescription drug plan, we enable people, businesses, and communities to manage health in more affordable, effective ways. We are delivering break-through products and services, from advising patients on their medications at our CVS Pharmacy® locations, to introducing unique programs to help control costs for our clients at CVS Caremark®, to innovating how care is delivered to our patients with complex conditions through CVS Specialty®, to improving pharmacy care for the senior community through Omnicare®, or by expanding access to high-quality, low-cost care at CVS MinuteClinic®.

We have three reportable segments: Pharmacy Services, Retail/LTC and Corporate.

Proposed Acquisition of Aetna

On December 3, 2017, we entered into a definitive merger agreement to acquire all of the outstanding shares of Aetna Inc. ("Aetna") for a combination of cash and stock (the "Aetna Acquisition"). Under the terms of the merger agreement, Aetna shareholders will receive $145.00 per share in cash and 0.8378 CVS Health shares for each Aetna share. The transaction values Aetna at approximately $207 per share or approximately $69 billion based on the Company's 5-day volume weighted average price ending December 1, 2017 of $74.21 per share. Including the assumption of Aetna's debt, the total value of the transaction is approximately $77 billion. The final purchase price will be determined based on the Company's stock price on the date of closing of the transaction.

The proposed acquisition is currently projected to close in the second half of 2018 and remains subject to approval by CVS Health and Aetna shareholders and customary closing conditions, including the expiration of the waiting period under the federal Hart-Scott-Rodino Antitrust Improvements Act of 1976 ("HSR Act") and approvals of state departments of insurance and U.S. and international regulators.

Pharmacy Services Segment

The Pharmacy Services Segment provides a full range of pharmacy benefit management ("PBM") solutions, as described more fully below, to clients consisting primarily of employers, insurance companies, unions, government employee groups, health plans, Medicare Part D plans, Managed Medicaid plans, plans offered on the public and private exchanges, other sponsors of health benefit plans and individuals throughout the United States. In addition, through our SilverScript Insurance Company ("SilverScript") subsidiary, we are a national provider of drug benefits to eligible beneficiaries under the federal government's Medicare Part D program. The Pharmacy Services Segment operates under the CVS Caremark Pharmacy Services, Caremark®, CVS Specialty®, AccordantCare™, SilverScript®, Wellpartner®, NovoLogix®, Coram®, Navarro® Health Services and ACS

Pharmacy names. As of December 31, 2017, the Pharmacy Services Segment operated 23 retail specialty pharmacy stores, 18 specialty mail order pharmacies and four mail order dispensing pharmacies, and 83 branches for infusion and enteral services, including approximately 73 ambulatory infusion suites and three centers of excellence, located in 42 states, Puerto Rico and the District of Columbia. During the year ended December 31, 2017, our PBM filled or managed approximately 1.8 billion prescriptions on a 30-day equivalent basis.

Pharmacy Services Business Strategy - Our pharmacy services business strategy centers on providing innovative tools and strategies, as well as quality client service, in order to help improve clinical outcomes for our clients' plan members while assisting them with better managing pharmacy and overall health care costs. Our goal is to produce superior results for our clients and their plan members by leveraging our expertise in core PBM services, including: plan design offerings and administration, formulary management, Medicare Part D services, mail order, specialty pharmacy and infusion services, retail pharmacy network management services, prescription management systems, clinical services, disease management services and medical spend management.

In addition, as a fully integrated pharmacy services company that helps clients improve quality and lower their pharmacy costs, we offer our clients and their plan members a variety of programs and tools, including plan design offerings, that benefit from our integrated systems and the ability of our almost 36,000 pharmacists, nurses, nurse practitioners and physician assistants to interact personally with the many plan members we serve. Through our multiple member touch points (retail stores, mail order, infusion, long-term care and specialty pharmacies, retail clinics, digital resources and cost management tools), we seek to engage plan members in behaviors that help lower cost and improve health care outcomes. Examples of these programs and services include: Maintenance Choice®, a program where eligible client plan members can elect to fill their maintenance prescriptions through delivery to their home or business or at our CVS Pharmacy retail stores for the same price as mail order; Pharmacy Advisor®, a program that facilitates face-to-face and telephone counseling by our pharmacists to help participating plan members with certain chronic diseases, such as diabetes and cardiovascular conditions, to identify gaps in care, adhere to their prescribed medications and manage their health conditions; enhanced disease management programs, such as our TransformCare™ offerings, that are targeted at managing chronic disease states; Specialty Connect®, our specialty pharmacy offering that integrates specialty mail and retail capabilities, providing members with disease-state specific counseling from our experienced specialty pharmacists and the convenience of picking up their prescriptions at their local CVS Pharmacy or having them delivered to their home or office and an ExtraCare® Health Card program that offers discounts to eligible plan members on certain over-the-counter health care products sold in our CVS Pharmacy stores. In addition, CVS MinuteClinic ("MinuteClinic") is an important and differentiated part of the enterprise that offers certain capabilities to PBM clients and their members. For example, we offer plan-sponsored co-pay reductions to encourage use of MinuteClinic, thereby helping to reduce emergency room visits and to lower overall health care costs. We also partner with our health plan clients sponsoring patient-centered medical homes, biometric screenings for plan members, closing gaps in care, and onsite clinics at client corporate headquarters.

PBM Services - Our PBM solutions are described more fully below.

Plan Design Offerings and Administration - We administer pharmacy benefit plans for clients who contract with us to facilitate prescription coverage and claims processing for their eligible plan members. We assist our clients in designing pharmacy benefit plans that help improve health outcomes while minimizing the costs to the client. We also assist clients in monitoring the effectiveness of their plans through frequent, informal communications, their use of our proprietary software, as well as through formal annual, quarterly and sometimes monthly performance reviews.

We make recommendations to help clients design benefit plans that promote the use of the lower cost, clinically appropriate drugs. We help our clients control costs by recommending plan designs that encourage the use of generic equivalents of brand name drugs when such equivalents are available. Our clients also have the option, through plan design, to further lower their pharmacy benefit plan costs by setting different member payment levels for different products on their drug lists or "formularies," which helps guide members to choose lower cost alternatives through appropriate financial incentives.

Formulary Management - We utilize an independent panel of doctors, pharmacists and other medical experts, referred to as our CVS Caremark National Pharmacy and Therapeutics Committee, to review and approve the selection of drugs that meet our high standards of safety and efficacy for inclusion on one of our template formularies. Our formularies provide

recommended products in numerous drug classes to help ensure member access to clinically appropriate drugs with alternatives within a class under the client's pharmacy benefit plan, while helping to drive the lowest net cost for our clients that select one of our formularies. To help improve clinical outcomes for members and clients, we conduct ongoing, independent reviews of all drugs, including, but not limited to, those appearing on the formularies and generic equivalent products. Many of our clients choose to adopt one of our template formulary offerings as part of their plan design. Beginning in 2018, clients will have new capabilities to offer real time benefits information for a member's specific plan design, provided digitally at the point of prescribing, at the pharmacy and directly to members.

Medicare Part D Services - We participate in the administration of the drug benefit added to the Medicare program under Part D of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”) through the provision of PBM services to those of our health plan clients and other clients that have qualified as a Medicare Part D prescription drug plans (“PDP”) or as a Medicare Advantage prescription drug plan (“MA-PD”) and by offering Medicare Part D pharmacy benefits through SilverScript, a PDP that has contracted with the United States Centers for Medicare and Medicaid Services (“CMS”). We also assist employer, union and other health plan clients that qualify for the retiree drug subsidy made available under the MMA by collecting and submitting eligibility and/or drug cost data to CMS in order for them to obtain the subsidy and offer Medicare Part D pharmacy benefits to such clients' retirees through SilverScript-sponsored Employer Group Waiver Plans (“EGWPs”).

Mail Order Pharmacy - As of December 31, 2017, we operated four mail order dispensing pharmacies in the United States. Plan members or their prescribers submit prescriptions or refill requests, primarily for maintenance medications, to these pharmacies via mail, telephone, fax, e-prescribing or the Internet. We also operate a network of smaller mail order specialty pharmacies described below. Our staff pharmacists review mail order prescriptions and refill requests with the assistance of our prescription management systems. This review may involve communications with the prescriber and, with the prescriber’s approval when required, can result in generic substitution, therapeutic interchange or other actions designed to help reduce cost and/or improve quality of treatment. These pharmacies have been awarded Mail Order Pharmacy accreditation from Utilization Review Accreditation Commission (“URAC”), a Washington DC-based health care accrediting organization that establishes quality standards for the health care industry.

Specialty Pharmacy - Our specialty pharmacies support individuals who require complex and expensive drug therapies. As of December 31, 2017, our specialty pharmacy operations included 18 specialty mail order pharmacies located throughout the United States, including Puerto Rico, that are used for delivery of advanced medications to individuals with chronic or genetic diseases and disorders. These pharmacies have also been awarded Specialty Pharmacy accreditation from URAC. As of December 31, 2017, the Company operated a network of 23 retail specialty pharmacy stores, which operate under the CVS Pharmacy specialty services and Navarro® Health Services names. These stores average 1,100 square feet in size and sell prescription drugs and a limited assortment of front store items such as alternative medications, homeopathic remedies and vitamins. Our care management program, AccordantCare, is a differentiated clinical model that focuses on whole patient care, including comorbidity management. It embeds specially trained nurses into the CVS Specialty CareTeam for members who fill their specialty medications through CVS Specialty helping deliver better care and improved outcomes. Through our affiliate Coram LLC and its subsidiaries (collectively, “Coram”), one of the nation’s largest providers of comprehensive infusion services, we care for approximately 165,000 patients annually, providing specialty infusion and enteral nutrition services. Our Specialty Connect® offering integrates our specialty pharmacy mail and retail capabilities, providing members with disease-state specific counseling from our experienced specialty pharmacists and the convenience of picking-up their prescriptions at their local CVS Pharmacy, or having them delivered to their preferred address. Whether submitted through our specialty mail order pharmacy or at a CVS Pharmacy, all prescriptions are filled through our specialty mail order pharmacies, so all revenue from this specialty prescription services program is recorded within the Pharmacy Services Segment. Members then can choose to pick up their medication at their local CVS Pharmacy, or have it sent to their home through the mail. Specialty Connect is available where allowed by law. Innovative digital tools for specialty pharmacy provide a more accessible, connected, and personal health experience. Members can manage all their specialty medications in real-time using the CVS Specialty app and more than 60 percent have opted in to receive email and text messages including refill reminders and order status. Patients can also use secure messaging to contact their Specialty CareTeam with any questions. Additionally, with the acquisition of Omnicare, Inc. (“Omnicare”), we expanded our specialty pharmacy to include the specialty pharmacy operations of Omnicare which operates under the name ACS Pharmacy.

Retail Pharmacy Network Management - We maintain a national network of more than 68,000 retail pharmacies, consisting of approximately 41,000 chain pharmacies (which includes our CVS Pharmacy locations) and 27,000 independent pharmacies, in the United States, including Puerto Rico, the District of Columbia, Guam and the U.S. Virgin Islands. When a customer fills a prescription in a retail pharmacy, the pharmacy sends prescription data electronically to us from the point-of-sale. This data interfaces with our proprietary prescription management systems, which verify relevant plan member data and eligibility, while also performing a drug utilization review to help evaluate clinical appropriateness and safety and confirming that the pharmacy will receive payment for the prescription. We are also able to build client-specific networks and managed network solutions to further drive savings for our clients. These include a performance-based pharmacy network with approximately 30,000 stores that will be anchored by CVS Pharmacy and Walgreens, along with up to 10,000 community-based, independently owned pharmacies across the United States. The network is designed to deliver unit cost savings and to improve clinical outcomes that will help to lower overall health

care costs for participating payors and their members. This network will be available beginning March 2018 to eligible commercial and Medicaid clients.

Prescription Management Systems - We dispense prescription drugs both directly, through one of our mail order or specialty pharmacies, or through a network of retail pharmacies, described above. All prescriptions processed through our systems, whether they are filled through one of our mail order or specialty dispensing pharmacies or through a pharmacy in our retail network, are analyzed, processed and documented by our proprietary prescription management systems. These systems provide essential features and functionality to allow a plan member to use their prescription drug benefit. These systems also streamline the process by which prescriptions are processed by staff and network pharmacists, by enhancing review of various items through automation, including, but not limited to, plan eligibility, early refills, duplicate dispensing, appropriateness of dosage, drug interactions or allergies, over-utilization and potential fraud.

Clinical Services - We offer multiple clinical programs and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner. Our programs are primarily designed to promote good health outcomes, and to help target inappropriate utilization and non-adherence to medication, each of which may result in adverse medical events that negatively impact member health and client pharmacy and medical spend. In this regard, we offer various utilization management ("UM"), medication management, quality assurance, adherence and counseling programs to complement the client's plan design and clinical strategies. To help address the opioid epidemic, we introduced an industry-leading UM approach that limits to seven days the supply of opioids dispensed for certain acute prescriptions for patients who are new to therapy; limits the daily dosage of opioids dispensed based on the strength of the opioid; and requires the use of immediate-release formulations of opioids before extended-release opioids are dispensed. To support improved adherence, our Pharmacy Advisor program facilitates pharmacist counseling, both face-to-face and over the telephone, to help participating plan members with certain chronic diseases, such as diabetes and cardiovascular conditions, to identify gaps in care, adhere to their prescribed medications and manage their health conditions. We also have digital connectivity that helps to lower drug costs for patients by providing expanded visibility to lower cost alternatives through enhanced analytics and data sharing.

Disease Management Programs - Our clinical services utilize advanced protocols and offer clients convenience in working with health care providers and other third parties. Our AccordantCare programs include integrated rare disease management programs, which cover diseases such as rheumatoid arthritis, Parkinson's disease, seizure disorders and multiple sclerosis. The majority of these integrated programs are accredited by the National Committee for Quality Assurance ("NCQA"), a private, not-for-profit organization that evaluates, accredits and certifies a wide range of health care organizations. They have also been awarded Case Management accreditation from URAC.

Medical Benefit Management - We offer a technology platform, NovoLogix®, an online preauthorization tool that helps identify and capture cost savings opportunities for specialty drugs billed under the medical benefit by identifying outliers to appropriate dosages and costs, and helps to ensure clinically appropriate use of these drugs.

Pharmacy Services Information Systems - We currently operate and support a small number of claim adjudication platforms to support our Pharmacy Services Segment. However, the majority of our clients have migrated to one platform. These information systems incorporate architecture that centralizes the data generated from filling mail order prescriptions, adjudicating retail pharmacy claims and delivering other solutions to our PBM clients. Our Health Engagement Engine® technology and proprietary clinical algorithms help connect the various parts of the enterprise and serves an essential role in cost management and health improvement. This capability responsibly transforms pharmacy data into actionable interventions at key points of care such as our mail and specialty pharmacists to help provide quality care, and our enterprise digital strategy and integrated digital offerings help patients seamlessly manage mail, specialty and retail prescriptions.

Pharmacy Services Clients - Our clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D plans, Managed

Medicaid plans and plans offered on public and private exchanges, other sponsors of health benefit plans and individuals located throughout the United States. We provide pharmaceuticals to eligible members in benefit plans maintained by our clients and utilize our information systems, among other things, to help perform safety checks, drug interaction screening and identify opportunities for generic substitution. We generate substantially all of our Pharmacy Services Segment net revenue from dispensing and managing prescription drugs to eligible members in benefit plans maintained by our clients. In 2017, 2016 and 2015, net revenues from Aetna accounted for approximately 12.3%, 11.7% and 10.0%, respectively, of our consolidated net revenues.

Pharmacy Services Seasonality - The majority of our Pharmacy Services Segment revenues are not seasonal in nature. However, our quarterly earnings and operating cash flows are impacted by the Medicare Part D benefit design and changes in the composition of our membership. The Medicare Part D standard benefit design results in coverage that varies with a member's cumulative annual out-of-pocket costs. The benefit design generally results in plan sponsors sharing a greater portion of the responsibility for total prescription drug costs in the early part of the year. As a result, the PDP pay percentage or benefit ratio generally decreases and operating profit generally increases as the year progresses.

Pharmacy Services Competition - We believe the primary competitive factors in the industry include: (i) the ability to negotiate favorable discounts from drug manufacturers as well as to negotiate favorable discounts from, and access to, retail pharmacy networks; (ii) the ability to identify and apply effective cost management programs utilizing clinical strategies including the development and utilization of preferred formularies; (iii) the ability to market PBM products and services; (iv) the commitment to provide flexible, clinically-oriented services to clients and be responsive to clients' needs; (v) the quality, scope and costs of products and services offered to clients and their members including satisfaction of experience; and (vi) operational excellence in delivering services. The Pharmacy Services Segment has a significant number of competitors (e.g., Express Scripts, OptumRx, Prime Therapeutics, MedImpact, and Humana) offering PBM services including large, national PBM companies, PBMs owned by large national health plans and smaller standalone PBMs.

Retail/LTC Segment

As of December 31, 2017, the Retail/LTC Segment included 9,803 retail locations (of which 8,060 were our stores that operated a pharmacy and 1,695 were our pharmacies located within Target Corporation ("Target") stores), our online retail pharmacy websites, CVS.com®, Navarro.com™ and Onofre.com.br™, 37 onsite pharmacy stores, our long-term care pharmacy operations and our retail health care clinics. The retail locations are in 49 states, the District of Columbia, Puerto Rico and Brazil, operating primarily under the CVS Pharmacy®, CVS®, CVS Pharmacy y más®, Longs Drugs®, Navarro Discount Pharmacy® and Drogaria Onofre™ names. Including the pharmacies within Target, we currently operate in all of the top 100 United States drugstore markets. Existing retail stores range in size from approximately 5,000 to 30,000 square feet, although most new stores range in size from approximately 11,000 to 15,000 square feet and typically include a drive-thru pharmacy. The pharmacies within Target stores range in size from approximately 450 to 1,100 square feet. During 2017, our Retail/LTC Segment filled approximately 1.2 billion prescriptions (counting 90-day prescriptions as three prescriptions), and we held approximately 23.6% of the United States retail pharmacy market.

Our acquisition of Omnicare broadened our base of pharmacy care to an additional dispensing channel, long-term care pharmacy. Omnicare's LTC operations include the distribution of pharmaceuticals, related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. Omnicare also provided commercialization services under the name RxCrossroads until January 2, 2018, when we completed the sale of RxCrossroads. LTC is comprised of 145 spoke pharmacies that primarily handle new prescription orders, of which 30 are also hub pharmacies that use automation to support spoke pharmacies with refill prescriptions. LTC primarily operates under the Omnicare® and NeighborCare® names. With the addition of the LTC operations, we are continuing to enhance our service offerings to further address the needs of an aging population throughout the continuum of senior care.

Retail Pharmacy Business Strategy - Our integrated pharmacy services model has enhanced the ability of our retail pharmacy stores to expand customer access to care while helping to lower overall health care costs and improve health outcomes. In that regard, the role of our retail pharmacist is shifting from primarily dispensing prescriptions to also providing services, including flu vaccinations as well as face-to-face patient counseling with respect to adherence to drug therapies, closing gaps in care and recommending more cost effective drug therapies. We also provide a broad assortment of quality merchandise at competitive prices using a retail format that emphasizes service, innovation and convenience.

One of the keys to our strategy is technology, which allows us to focus on constantly improving service and exploring ways to provide more personalized product offerings and services. We are continuing to leverage digital to empower our customers and patients by making the full breadth of health care and pharmacy services available to them anytime, anywhere. We are continuing to introduce digital tools to make it easier for people to save time and money and to live healthier lives. In 2017, we rolled out CVS Pay® nationwide, an end-to-end mobile payment solution that integrates payment, prescription pick-up and our ExtraCare® loyalty program into one spot at checkout. We believe that continuing to innovate with new and unique products and services, using innovative marketing and adjusting our mix of merchandise to match our customers' needs and preferences is very important to our ability to continue to improve customer satisfaction.

Retail/LTC Products and Services - A typical retail store sells prescription drugs and a wide assortment of high-quality, nationally advertised brand name and proprietary brand merchandise. Front store categories include over-the-counter drugs, beauty products and cosmetics, personal care products, convenience foods, photo finishing services, seasonal merchandise and greeting cards. The pharmacies within Target stores sell prescription drugs and over-the-counter drugs that are required to be held behind the counter. The LTC operations include distribution of pharmaceuticals and related consulting and ancillary services. We purchase our merchandise from numerous manufacturers and distributors. We believe that competitive sources are readily available for substantially all of the products we carry and the loss of any one supplier would not likely have a material effect on the business. Our clinics offer a variety of health care services by nurse practitioners and physician assistants.

Retail/LTC net revenues by major product group are as follows:

	Percentage of Net Revenues		
	2017	2016	2015
Pharmacy [(1)]	75.0 %	75.0 %	72.9 %
Front store and other [(2)]	25.0	25.0	27.1
	100.0 %	100.0 %	100.0 %

(1) Pharmacy includes LTC sales and sales in pharmacies within Target stores.

(2) "Other" represents less than 5% of the "Front store and other" net revenue category.

Pharmacy - Pharmacy revenues represented approximately three-fourths of the Retail Pharmacy Segment revenues in each of 2017, 2016 and 2015. We believe that our retail pharmacy operations will continue to represent a critical part of our business due to industry demographics, e.g., an aging American population consuming a greater number of prescription drugs, pharmaceuticals being used more often as the first line of defense for managing illness, the introduction of new pharmaceutical products, and Medicare Part D. We believe our retail pharmacy business benefits from our investment in both people and technology, as well as our innovative partnerships with health plans, PBMs and providers. Given the nature of prescriptions, people want their prescriptions filled accurately by professional pharmacists using the latest tools and technology, and ready when promised. Consumers need medication management programs and better information to help them get the most out of their health care dollars. To assist our customers with these needs, we have introduced integrated pharmacy health care services that provide an earlier, easier and more effective approach to engaging them in behaviors that can help lower costs, improve health, and save lives. Examples include: our Patient Care Initiative, an enhanced medication adherence program; Maintenance Choice®, a program where eligible client plan members can elect to fill their maintenance prescriptions through delivery to their home or business or at our CVS Pharmacy retail stores for the same price as mail order; Pharmacy Advisor®, our program that facilitates pharmacist counseling, both face-to-face and over the telephone, to help participating plan members with certain chronic diseases, such as diabetes and cardiovascular conditions, to identify gaps in care, adhere to their prescribed medications and manage their health conditions; Specialty Connect®, which integrates our specialty pharmacy mail and retail capabilities, providing members with disease-state specific counseling from our experienced specialty pharmacists and the convenience of picking-up their prescriptions at their local CVS Pharmacy, or having them delivered to their preferred address; ScriptSync®, a service that enables patients with multiple medications to pick up their eligible maintenance prescriptions in a single monthly CVS Pharmacy visit; ScriptPath™ Prescription Schedule, a new capability for CVS Pharmacy patients, who manage multiple prescription medications, which features all of a patient's current CVS Pharmacy prescription information in one place – including which medications the patient takes, when the patient should take them and how much of each medication should be taken in each dose; and HealthTag®, an integrated communications platform that can be leveraged to communicate healthcare opportunities to members that provides unmatched ability to reach and connect with members as well as industry-leading data integration to improve coordination of member care. Each of these are programs that demonstrate our ability to enhance the customer

experience through our integrated enterprise products and services. Further evidencing our belief in the importance of pharmacy service is our continuing investment in technology, such as our Drug Utilization Review system that helps check for harmful interactions between prescription drugs and patient identified over-the-counter products, vitamins and herbal remedies; RxConnect, our proprietary pharmacy system that integrates our product delivery and clinical workflows as well as advanced patient safety functionality such as drug utilization review; our prescription refill program, ReadyFill®; and our online retail businesses, CVS.com, Navarro.com and Onofre.com.br. Our Health Engagement Engine enables patient-specific opportunities to be prioritized and delivered at each key moment of care relevant to that specific patient. In December 2015, we expanded our pharmacy offering with the acquisition of the

pharmacies within Target stores. We offer all the same pharmacy services available in our retail drugstores and online at our pharmacies within Target stores.

Front Store - Front store revenues benefited from our strategy to innovate with new and unique products and services, using innovative personalized marketing and adjusting our mix of merchandise to match our customers' needs and preferences. A key component of our front store strategy is our ExtraCare® card program, which is helping us continue to build our loyal customer base. The ExtraCare program is one of the largest and most successful retail loyalty programs in the United States. The ExtraCare program allows us to balance our marketing efforts so we can reward our best customers by providing them automatic sale prices, customized coupons, ExtraBucks® rewards and other benefits. We continue to launch and enhance new and exclusive brands to create unmatched offerings in beauty. Another component of our front store strategy is our unique product offerings, which include a full range of high-quality CVS Pharmacy® and proprietary brand products that are only available through CVS Pharmacy stores. We currently carry approximately 7,000 CVS Pharmacy and proprietary brand products, which accounted for approximately 23% of our front store revenues during 2017. These products include expanded offerings of healthy foods and vitamins. Furthermore, we are tailoring certain groups of stores, such as suburban area stores, to better meet the needs of our customers.

MinuteClinic - As of December 31, 2017, we operated 1,134 MinuteClinic® locations in 33 states and the District of Columbia, of which 1,050 were located in our retail pharmacy stores, and 79 were located in Target stores. We opened 15 new clinics during 2017. Our clinics are staffed by nurse practitioners and physician assistants who utilize nationally established guidelines to diagnose and treat minor health conditions, perform health screenings, monitor chronic conditions, provide wellness services and deliver vaccinations. Payors value our clinics because they provide convenient, high-quality, cost-effective care, in many cases offering an attractive alternative to more expensive sites of care. As a result, visits paid for by employers, health insurers or other third parties accounted for approximately 91% of MinuteClinic's total revenues in 2017. MinuteClinic is collaborating with our Pharmacy Services Segment to help meet the needs of CVS Caremark's client plan members by offering programs that can improve member health and lower costs. MinuteClinic is now affiliated with more than 75 major health systems and continues to build a platform that supports primary care.

Long-term Care - Through our Omnicare business, we provide the distribution of pharmaceuticals, related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. Omnicare's customers consist of skilled nursing facilities, assisted living facilities, independent living communities, hospitals, correctional facilities, and other health care service providers. We provide pharmacy consulting, including monthly patient drug therapy evaluations, assist in compliance with state and federal regulations and provide proprietary clinical and health management programs. We also provide pharmaceutical case management services for retirees, employees and dependents who have drug benefits under corporate-sponsored health care programs.

Onsite Pharmacies - We also operate a limited number of small pharmacies located at client sites, typically under the CarePlus®, CarePlus CVS Pharmacy® or CVS Pharmacy® name, which provide certain health plan members and customers with a convenient alternative for filling their prescriptions.

Retail Pharmacy Drugstore Development - The addition of new stores has played, and will continue to play, a key role in our continued growth and success. Our store development program focuses on three areas: entering new markets, adding stores within existing markets and relocating stores to more convenient sites. During 2017, we opened 175 new retail locations, relocated 30 stores and closed 81 locations. During the last five years, we opened approximately 1,000 new and relocated locations, and acquired 1,880 locations including the pharmacies acquired from Target. We believe that continuing to grow our store base and locating stores in more accessible markets are essential components to compete effectively in the current health care environment. As a result, we believe that our store development program is an integral part of our ability to maintain our leadership position given the changing health care landscape and to meet the increasing needs of our customers.

Retail/LTC Information Systems - We have continued to invest in information systems to enable us to deliver exceptional customer service, enhance safety and quality, and expand our patient care services while lowering operating costs. Our proprietary WeCARE Workflow supports our pharmacy teams by prioritizing work to meet customer expectations, facilitating prescriber outreach, and seamlessly integrating our clinical programs. This solution delivers improved efficiency and enhances the customer experience, as well as providing a framework to accommodate the evolution of pharmacy practice and the expansion of our clinical programs. Our Health Engagement Engine technology and proprietary clinical algorithms enable us to help identify opportunities for our pharmacists to deliver face-to-face

counseling regarding patient health and safety matters, including adherence issues, gaps in care and management of certain chronic health conditions. Our digital strategy empowers the consumer to navigate their pharmacy experience and manage their condition through our on-line and mobile tools that offer utility and convenience. This includes the ability to schedule an appointment at MinuteClinic, get next-in line alerts or health reminders and appointment updates via text messages. Our integrated digital offerings help patients seamlessly manage retail, mail and specialty prescriptions dispensed by a CVS Pharmacy or LTC location and enhance front store personalization to drive value for customers. We continue to experience strong adoption of our digital solutions with our mobile app receiving critical acclaim for ease of use and our text message program experiencing significant growth. LTC's digital technology suite, Omniview®, improves the efficiency of customers' operations with tools that include executive dashboards, pre-admission pricing, electronic ordering of prescription refills, proof-of-delivery tracking, access to patient profiles, receipt and management of facility bills, and real-time validation of Medicare Part D coverage, among other capabilities.

Retail/LTC Customers - The success of our retail drugstore and LTC businesses is dependent upon our ability to establish and maintain contractual relationships with pharmacy benefit managers and other payors on acceptable terms. Pharmacy benefit managers, managed care organizations, government-funded health care programs, commercial employers and other third party payors accounted for 99.2% of our 2017 pharmacy revenues. No single Retail/LTC payor accounts for 10% or more of our annual consolidated net revenues.

Retail/LTC Seasonality - The majority of our revenues, particularly pharmacy revenues, are generally not seasonal in nature. However, retail front store revenues tend to be higher during the December holiday season. In addition, both pharmacy and retail front store revenues are affected by the timing and severity of the cough, cold and flu season. For additional information, we refer you to "Risks related to the seasonality of our business" in Item 1A. Risk Factors.

Retail/LTC Competition - The retail drugstore business is highly competitive. We believe that we compete principally on the basis of: (i) store location and convenience, (ii) customer service and satisfaction, (iii) product selection and variety, and (iv) price. In the markets we serve, we compete with other drugstore chains (e.g., Walgreens and Rite Aid), supermarkets, discount retailers (e.g., Wal-Mart), independent pharmacies, restrictive pharmacy networks, membership clubs, Internet companies, and retail health clinics (including urgent care centers), as well as other mail order pharmacies.

LTC pharmaceutical services are highly regional or local in nature and within a given geographic area of operation, highly competitive. Our largest competitor nationally is PharMerica. We also compete with numerous local and regional institutional pharmacies, pharmacies owned by long-term care facilities and local retail pharmacies. Some states have enacted "freedom of choice" or "any willing provider" requirements as part of their state Medicaid programs or in separate legislation, which may increase the competition that we face in providing services to long-term care facility residents in these states.

Corporate Segment

Our Corporate Segment provides management and administrative services to support the overall operations of the Company. The Corporate Segment consists of certain aspects of our executive management, corporate relations, legal, compliance, human resources, information technology and finance departments.

Generic Sourcing Venture

The Company and Cardinal Health, Inc. ("Cardinal") each have a 50% ownership in Red Oak Sourcing, LLC ("Red Oak"), a generic pharmaceutical sourcing entity. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak; however, Red Oak does not own or hold inventory on behalf of either company.

Working Capital Practices

We fund the growth of our business through a combination of cash flow from operations, commercial paper and other short-term borrowings, proceeds from sale-leaseback transactions and long-term borrowings. For additional information on our working capital practices, we refer you to the caption “Management’s Discussion and Analysis - Liquidity and Capital Resources” in our Annual Report to Stockholders for the year ended December 31, 2017, which section is

incorporated by reference herein. The majority of our non-pharmacy revenues are paid in cash, or with debit or credit cards. Managed care organizations, pharmacy benefit managers, government-funded health care programs, commercial employers and other third party insurance programs, which represent the vast majority of our consolidated pharmacy revenues, typically settle in less than 30 days. With the exception of our Medicare Part D services, the remainder of our consolidated pharmacy revenues are paid in cash, or with debit or credit cards. As a provider of Medicare Part D services, we contract annually with CMS. Utilization of services each plan year results in the accumulation of either a receivable from or a payable to CMS. The timing of settlement of the receivable or payable with CMS takes several quarters which impacts our working capital from year to year.

Colleague Development

As of December 31, 2017, we employed approximately 246,000 colleagues in 50 states, the District of Columbia, Puerto Rico and Brazil, which included approximately 36,000 pharmacists, nurses, nurse practitioners and physician assistants. The total included approximately 86,000 part-time colleagues who work less than 30 hours per week. To deliver the highest levels of service to our customers, we devote considerable time and attention to our people and service standards. We emphasize attracting and training knowledgeable, friendly and helpful associates to work in our organization.

Intellectual Property

We have registered and/or applied to register a variety of our trademarks and service marks used throughout our business, as well as domain names, and rely on a combination of copyright, patent, trademark and trade secret laws, in addition to contractual restrictions, to establish and protect our proprietary rights. We regard our intellectual property as having significant value in our Pharmacy Services and Retail/LTC segments. We are not aware of any facts that could materially impact our continuing use of any of our intellectual property.

Government Regulation

Overview - Much of our business is subject to federal and state laws and regulations. In addition, many of our PBM clients and our payors in the Retail/LTC Segment, including insurers, Medicare Part D plans, Managed Medicaid plans and managed care organizations (“MCOs”), are themselves subject to extensive regulations that affect the design and implementation of prescription drug benefit plans that they sponsor. Similarly, our LTC clients, such as skilled nursing facilities, are subject to government regulations, including many of the same government regulations to which we are subject. The application of these complex legal and regulatory requirements to the detailed operation of our business creates areas of uncertainty. Further, there are numerous proposed health care laws and regulations at the federal and state levels, some of which could adversely affect our business if they are enacted. We are unable to predict what federal or state legislation or regulatory initiatives may be enacted in the future relating to our business or the health care industry in general, or what effect any such legislation or regulations might have on our business. Any failure or alleged failure to comply with applicable laws and regulations as summarized below, or any adverse applications of, or changes in, the laws and regulations affecting our business, could have a material adverse effect on our operating results and/or financial condition. See Item 3, “Legal Proceedings” for further information.

Although we believe that we are in material compliance with existing laws and regulations applicable to our various business lines, we cannot give any assurances that our business, financial condition and results of operations will not be materially adversely affected, or that we will not be required to materially change our business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations, including the laws and regulations described in this Government Regulation section, as they may relate to our business, the pharmacy services, retail pharmacy, long-term care or retail clinic industry or to the health care industry generally; (iii) pending or future federal or state governmental investigations of our business or the pharmacy services, retail pharmacy, long-term care or retail clinic industry or of the health care industry generally; (iv) institution of government enforcement actions against us; (v) adverse developments in any pending *qui tam* lawsuit against us, whether sealed or

unsealed, or in any future *qui tam* lawsuit that may be filed against us; or (vi) adverse developments in other pending or future legal proceedings against us or affecting the pharmacy services, retail pharmacy, long-term care or retail clinic industry or the health care industry generally.

Laws and Regulations Related to Each Operating Segment of Our Business

Laws Related to Reimbursement by Government Programs - We are subject to various state and federal laws concerning our submission of claims for reimbursement by Medicare, Medicaid and other government-sponsored health care programs. Potential sanctions for violating these laws include recoupment or reduction of government reimbursement amounts, civil penalties, multiples damages, and exclusion from participation in government health care programs. Such laws include the federal False Claims Act ("FCA"), the federal Anti-Kickback statute, various state false claims acts and anti-kickback statutes, the federal "Stark Law" and related state laws. In particular, the FCA prohibits intentionally submitting, conspiring to submit, or causing to be submitted, false claims, records, or statements to the federal government, or intentionally failing to return overpayments, in connection with reimbursement by federal government programs. As part of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, "ACA"), the federal Anti-Kickback Statute was amended in 2010 to provide that any claim for government reimbursement violates the FCA where it results from a violation of the Anti-Kickback Statute. Most states have enacted false claims laws analogous to the FCA, and both federal and state false claims laws permit private individuals to file *qui tam* or "whistleblower" lawsuits on behalf of the federal or state government. Further, the federal Stark Law generally prohibits physicians from referring Medicare or Medicaid beneficiaries for certain services, including outpatient prescription drugs, to any entity with which the physician, or an immediate family member of the physician, has a financial relationship. The Stark Law further prohibits the entity receiving a prohibited referral from presenting a claim for reimbursement by Medicare or Medicaid for services furnished pursuant to the prohibited referral. Various states have enacted similar laws.

Anti-Remuneration Laws - Federal law prohibits, among other things, an entity from knowingly and willfully offering, paying, soliciting or receiving, subject to certain exceptions and "safe harbors," any remuneration to induce the referral of individuals or the purchase, lease or order of items or services for which payment may be made under Medicare, Medicaid or certain other federal health care programs. A number of states have similar laws, some of which are not limited to services paid for with government funds. Sanctions for violating these federal and state anti-remuneration laws may include imprisonment, criminal and civil fines, and exclusion from participation in Medicare, Medicaid and other government-sponsored health care programs.

Antitrust and Unfair Competition - The Federal Trade Commission ("FTC") has authority under Section 5 of the Federal Trade Commission Act ("FTCA") to investigate and prosecute practices that are "unfair trade practices" or "unfair methods of competition." Numerous lawsuits have been filed throughout the United States against pharmaceutical manufacturers, retail pharmacies and/or PBMs under various state and federal antitrust and unfair competition laws challenging, among other things: (i) brand drug pricing practices of pharmaceutical manufacturers, (ii) the maintenance of retail or specialty pharmacy networks by PBMs, and (iii) various other business practices of PBMs and retail pharmacies. To the extent that we appear to have actual or potential market power in a relevant market or CVS Pharmacy or CVS Specialty plays a unique or expanded role in a PBM product offering, our business arrangements and uses of confidential information may be subject to heightened scrutiny from an anti-competitive perspective and possible challenge by state or federal regulators or private parties.

Privacy and Confidentiality Requirements - Many of our activities involve the receipt, use and disclosure by us of personally identifiable information ("PII") as permitted in accordance with applicable federal and state privacy and data security laws, which require organizations to provide appropriate privacy and security safeguards for such information. In addition to PII, we use and disclose de-identified data for analytical and other purposes when permitted. Additionally, there are industry standards for handling credit card data known as the Payment Card Industry Data Security Standard, which are a set of requirements designed to help ensure that entities that process, store or transmit credit card information maintain a secure environment. Certain states have recently incorporated these requirements into state laws.

The federal Health Insurance Portability and Accountability Act of 1996 and the regulations issued thereunder (collectively, "HIPAA") impose extensive requirements on the way in which health plans, health care providers, health care clearinghouses (known as "covered entities") and their business associates use, disclose and safeguard protected health information ("PHI"). Criminal penalties and civil sanctions may be imposed for failing to comply with HIPAA standards. The Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), enacted as part of the American Recovery and Reinvestment Act of 2009, amended HIPAA to impose additional restrictions on third-party funded communications using PHI and the receipt of remuneration in exchange for PHI. It also extended HIPAA privacy and security requirements and penalties directly to business associates. In addition to HIPAA, state health privacy laws apply to the extent they are more protective of individual privacy than is HIPAA.

Finally, the Health Insurance Marketplaces (formerly known as the “exchanges”) are required to adhere to privacy and security standards with respect to PII, and to impose privacy and security standards that are at least as protective of PII as those the Health Insurance Marketplace has implemented for itself or non-Health Insurance Marketplace entities, which include insurers offering plans through the Health Insurance Marketplaces and their designated downstream entities, including PBMs and other business associates. These standards may differ from, and be more stringent than, HIPAA.

Consumer Protection Laws - The federal government has many consumer protection laws, such as the FTCA, the Federal Postal Service Act and the FTC’s Telemarketing Sales Rule. Most states also have similar consumer protection laws. These laws have been the basis for investigations, lawsuits and multi-state settlements relating to, among other matters, the marketing of loyalty programs and health care services, pricing accuracy, expired front store products, financial incentives provided by drug manufacturers to pharmacies in connection with therapeutic interchange programs and disclosures related to how personal data is used and protected.

Government Agreements and Mandates - The Company and/or its various affiliates are subject to certain consent decrees, settlement agreements, corrective action plans and corporate integrity agreements with various federal, state and local authorities relating to such matters as privacy practices, controlled substances, Medicare Part D prescription drug plans, expired products, environmental and safety matters, marketing and advertising practices, PBM, long term care and pharmacy operations and various other business practices. These agreements may contain certain ongoing reporting, monitoring or other compliance requirements for the Company. Failure to meet the Company’s obligations under these agreements could result in civil or criminal remedies, financial penalties, administrative remedies, and/or exclusion from participation in federal health care programs.

Environmental and Safety Regulation - Our business is subject to various federal, state and local laws, regulations and other requirements pertaining to protection of the environment, public health and employee safety, including, for example, regulations governing the management of hazardous substances, the cleaning up of contaminated sites, and the maintenance of safe working conditions in our stores, distribution centers and other facilities. Governmental agencies on the federal, state and local levels have, in recent years, increasingly focused on the retail and health care sectors’ compliance with such laws and regulations, and have at times pursued enforcement activities. Any failure to comply with these regulations could result in fines or other sanctions by government authorities.

Health Reform Legislation - Passed in 2010, ACA affects virtually every aspect of health care in the country. In addition to establishing the framework for every individual to have health coverage, ACA enacted a number of significant health care reforms. Many of these reforms affect the coverage and plan designs that are provided by our health plan clients. As a result, these reforms impact a number of our services and business practices. Some significant ACA provisions are still being finalized (e.g., implementation of the excise tax on high-cost employer-sponsored health coverage has been delayed by Congress) and parts of ACA may still face potential Congressional changes, so the full impact of ACA on our Company is still uncertain.

Pharmacy and Professional Licensure and Regulation - We are subject to a variety of intersecting state and federal statutes and regulations that govern the wholesale distribution of drugs; operation of retail, specialty, infusion, LTC and mail order pharmacies; licensure of facilities and professionals, including pharmacists, technicians and nurses; registration of facilities with the United States Drug Enforcement Administration (“DEA”) and analogous state agencies that regulate controlled substances; packaging, storing, shipping and tracking of pharmaceuticals; repackaging of drug products; labeling, medication guides and other consumer disclosures; interactions with prescribers and health care professionals; compounding of prescription medications; dispensing of controlled and non-controlled substances; counseling of patients; transfers of prescriptions; advertisement of prescription products and pharmacy services; security; inventory control; recordkeeping; reporting to Boards of Pharmacy, the United States Food and Drug Administration (“FDA”), the

Consumer Product Safety Commission, the DEA and related state agencies; and other elements of pharmacy practice. Pharmacies are highly regulated and have contact with a wide variety of local, state and federal agencies, with various powers to investigate, inspect, audit or solicit information, including Boards of Pharmacy and Nursing, the DEA, the FDA, the United States Department of Justice, the United States Department of Health and Human Services ("HHS") and others. Many of these agencies have broad enforcement powers, conduct audits on a regular basis, can impose substantial fines and penalties, and may revoke the license, registration or program enrollment of a facility or professional.

Telemarketing and Other Outbound Contacts - Certain federal and state laws, such as the Telephone Consumer Protection Act, give the FTC, Federal Communications Commission ("FCC") and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws may provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Laws and Regulations Related to Our Pharmacy Services Segment

In addition to the laws and regulations discussed above that may affect our business as a whole, we are subject to federal, state and local statutes and regulations governing the operation of our Pharmacy Services Segment specifically. Among these are the following:

PBM Laws and Regulation - Legislation seeking to regulate PBM activities in a comprehensive manner has been introduced or enacted in a number of states. This legislation could adversely impact our ability to conduct business on commercially reasonable terms in states where the legislation is in effect.

In addition, certain quasi-regulatory organizations, including the National Association of Boards of Pharmacy and the National Association of Insurance Commissioners ("NAIC") have issued model regulations or may propose future regulations concerning PBMs and/or PBM activities. Similarly, credentialing organizations such as NCQA and URAC may establish voluntary standards regarding PBM, mail or specialty pharmacy activities. While the actions of these quasi-regulatory or standard-setting organizations do not have the force of law, they may influence states to adopt their requirements or recommendations and influence client requirements for PBM or specialty pharmacy services. Moreover, any standards established by these organizations could also impact our health plan clients and/or the services we provide to them.

Medicare Part D - The Medicare Part D program, which makes prescription drug coverage available to eligible Medicare beneficiaries through private insurers, regulates all aspects of the provision of Medicare drug coverage, including enrollment, formularies, pharmacy networks, marketing, and claims processing. The Medicare Part D program has undergone significant legislative and regulatory changes since its inception, and continues to attract a high degree of legislative and regulatory scrutiny. The applicable government rules and regulations continue to evolve. CMS has imposed restrictions and issued new requirements to protect Medicare Part D beneficiaries and has used its authority to sanction and impose civil monetary penalties on plans for non-compliance.

Network Access Legislation - Medicare Part D and a majority of states now have some form of legislation affecting the ability to limit access to a pharmacy provider network or remove network providers. For example, certain "any willing provider" legislation may require us or our clients to admit a non-participating pharmacy if such pharmacy is willing and able to meet the plan's price and other applicable terms and conditions for network participation. These laws could negatively impact the services and economic benefits achievable through a limited pharmacy provider network.

Also, a majority of states now have some form of legislation affecting our ability (and the health plans' ability) to conduct audits of network pharmacies regarding claims submitted to us for payment. These laws could negatively impact our ability to recover overpayments in health care payments stemming from pharmacy audits. Lastly, several states have passed legislation regulating our ability to manage and establish maximum allowable costs ("MAC") for generic prescription drugs. MAC methodology is a common cost management practice used by private and public payors (including CMS) to pay pharmacies for dispensing generic prescription drugs. MAC prices specify the allowable reimbursement by a PBM for a particular strength and dosage of a generic drug that is available from multiple manufacturers but sold at different prices. State legislation can regulate the disclosure of MAC prices and MAC price methodologies, the kinds of drugs that a PBM can pay at a MAC price, and the rights of pharmacies to appeal a MAC price established by a PBM. These laws could negatively impact our ability to establish MAC prices for generic drugs.

Contract Audits - We are subject to audits of many of our contracts, including our PBM client contracts, our PBM rebate contracts, our PBM network contracts, our contracts relating to Medicare Part D and the agreements our pharmacies enter into with other payors. Because some of our contracts are with state or federal governments or with entities contracted with state or federal agencies, audits of these agreements are often regulated by the federal or state agencies responsible for administering federal or state benefits programs, including those which operate Medicaid fee for service plans, Managed Medicaid plans, Medicare Part D plans or Medicare Advantage organizations.

Federal Employee Health Benefits Program - We have a contractual arrangement with carriers for the Federal Employee Health Benefits ("FEHB") Program, such as the BlueCross BlueShield Association, to provide pharmacy services to federal employees, postal workers, annuitants, and their dependents under the Government-wide Service Benefit Plan, as authorized by the FEHB Act and as part of the FEHB Program. These arrangements subjects us to certain aspects of FEHB Act, and other federal regulations, such as the FEHB Acquisition Regulation, that otherwise are not applicable to us.

State Insurance Laws - PDPs and our PBM service contracts, including those in which we assume certain risks under performance guarantees or similar arrangements, are generally not subject to insurance regulation by the states. However, state departments of insurance are increasing their oversight of PBM activities due to legislation passing in several states requiring PBMs to register or obtain a license with the department. Rulemaking is either underway or has already taken place in a few states with the areas of focus on licensure requirements, pharmacy reimbursement for generics (MAC reimbursement) and pharmacy audits - most of which fall under the state insurance code. Additionally, some states have laws that prohibit submitting a false claim or making a false record or statement in order to secure reimbursement from an insurance company. These state laws vary, and violation of them may lead to the imposition of civil or criminal penalties.

As a PDP, SilverScript is subject to state insurance laws limited to licensure and solvency. In addition, PBM offerings of prescription drug coverage under certain risk arrangements may be subject to laws and regulations in various states. Such laws may require that the party at risk become licensed as an insurer, establish reserves or otherwise demonstrate financial viability. Laws that may apply in such cases include insurance laws and laws governing MCOs and limited prepaid health service plans.

ERISA Regulation - The Employee Retirement Income Security Act of 1974, as amended ("ERISA"), provides for comprehensive federal regulation of certain employee pension and benefit plans, including private employer and union sponsored health plans and certain other plans that contract with us to provide PBM services. In general, we assist plan sponsors in the administration of the prescription drug portion of their health benefit plans in accordance with the plan designs adopted by the plan sponsors. We do not believe that the conduct of our business subjects us to the fiduciary obligations of ERISA, except when we have specifically contracted with a plan sponsor to accept limited fiduciary responsibility, such as for the adjudication of initial prescription drug benefit claims and/or the appeals of denied claims under a plan, and with respect to the Contraceptive Coverage Mandate, one of the health reforms presently included in ACA.

In addition to its fiduciary provisions, ERISA imposes civil and criminal liability on service providers to health plans and certain other persons if certain forms of illegal remuneration are made or received. These provisions of ERISA are broadly written and their application to specific business practices is often uncertain.

Formulary and Plan Design Regulation - A number of government entities regulate the administration of prescription drug benefits. HHS regulates how Medicare Part D formularies are developed and administered, including requiring the inclusion of all drugs in certain classes and categories, subject to limited exceptions. Under ACA, CMS imposes drug coverage requirements for health plans required to cover essential health benefits, including plans offered through federal or state exchanges. Additionally, NAIC and health care accreditation agencies like NCQA and URAC have developed model acts and standards for formulary development that are often incorporated into government requirements. Many states regulate the scope of prescription drug coverage, as well as the delivery channels to receive such prescriptions, for insurers, MCOs and Medicaid managed care plans. The increasing government regulation of formularies could significantly affect our ability to develop and administer formularies, networks and other plan design features on behalf of our insurer, MCO and other clients. Similarly, some states prohibit health plan sponsors from implementing certain restrictive design features. This regulation could limit or preclude (i) limited networks, (ii) a requirement to use particular providers, (iii) copayment differentials among providers and (iv) formulary tiering practices.

Managed Care Reform - In addition to health reforms enacted by ACA, proposed legislation has been considered at the state level, and legislation has been enacted in several states, aimed primarily at providing additional rights and access to drugs to individuals enrolled in managed care plans. This legislation may impact the design and implementation of prescription drug benefit plans sponsored by our PBM health plan clients and/or the services we provide to them. Both the scope of the managed care reform proposals considered by state legislatures and reforms enacted by states to date vary greatly, and the scope of future legislation that may be enacted is uncertain.

Disease Management Services Regulation - We provide disease management programs to PBM plan members for rare medical conditions and arrange for them to receive disease management programs for common medical conditions. State laws regulate the practice of medicine, the practice of pharmacy and the practice of nursing. Clinicians engaged in a professional practice in connection with the provision of disease management services must satisfy applicable state licensing requirements and must act within their scope of practice.

Third Party Administration and Other State Licensure Laws - Many states have licensure or registration laws governing certain types of administrative organizations, such as preferred provider organizations, third party administrators and companies that provide utilization review services. Several states also have licensure or registration laws governing the organizations that provide or administer consumer card programs (also known as cash card or discount card programs).

Laws and Regulations Related to Our Retail/LTC Segment

In addition to the laws and regulations discussed above that may affect our business as a whole, we are subject to federal, state and local statutes and regulations governing the operation of our Retail/LTC Segment specifically. Among these are the following:

Specific FDA Regulation - The FDA generally has authority to, among other things, regulate the manufacture, distribution, sale and labeling of many products sold through retail pharmacies, including prescription drugs, over-the-counter medications, medical devices (including mobile medical devices), cosmetics, dietary supplements and certain food items.

Retail Clinics - States regulate retail clinics operated by nurse practitioners or physician assistants through physician oversight, lab licensing and the prohibition of the corporate practice of medicine. A number of states have implemented or proposed laws or regulations that impact certain components of retail clinic operations such as physician oversight, signage, third party contracting requirements, bathroom facilities, and scope of services. These laws and regulations may affect the operation and expansion of our owned and managed retail clinics.

Available Information

CVS Health Corporation is a Delaware corporation. Our corporate office is located at One CVS Drive, Woonsocket, Rhode Island 02895, telephone (401) 765-1500. Our common stock is listed on the New York Stock Exchange under the trading symbol “CVS.” General information about CVS Health is available through the Company’s Web site at *http://www.cvshealth.com*. Our financial press releases and filings with the United States Securities and Exchange Commission (“SEC”) are available free of charge within the Investors section of our Web site at *http://www.cvshealth.com/investors*. In addition, the SEC maintains an internet site that contains reports, proxy and information statements and other information regarding issuers, such as the Company, that file electronically with the SEC. The address of that Web site is *http://www.sec.gov.*

Item 1A. Risk Factors

Our business is subject to various industry, economic, regulatory and other risks and uncertainties. Our business, financial condition, results of operations, cash flows and prospects could be materially adversely affected by any one or more of the following risk factors and by additional risks and uncertainties not presently known to us or that we currently deem to be immaterial:

Risks of declining gross margins in the PBM, retail pharmacy and LTC pharmacy industries.

The PBM industry has been experiencing margin pressure as a result of competitive pressures and increased client demands for lower prices, increased revenue sharing, enhanced service offerings and/or higher service levels. In that regard, we maintain

contractual relationships with generic pharmaceutical manufacturers and brand name pharmaceutical manufacturers that provide for purchase discounts and/or rebates on drugs dispensed by pharmacies in our retail network and by our specialty and mail order pharmacies (all or a portion of which may be passed on to clients). Manufacturer rebates often depend on a PBM's ability to meet contractual market share or other requirements, including in some cases the placement of a manufacturer's products on the PBM's formularies. If we lose our relationship with one

or more pharmaceutical manufacturers, or if the discounts or rebates provided by pharmaceutical manufacturers decline, our business and financial results could be adversely affected. Further, competitive pressures in the PBM industry have resulted in our clients sharing in a larger portion of rebates and/or discounts received from pharmaceutical manufacturers. Market dynamics and regulatory changes have impacted our ability to offer plan sponsors pricing that includes the use of retail "differential" or "spread", which could negatively impact our future profitability. Further, changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to patent term extensions, purchase discount and rebate arrangements with pharmaceutical manufacturers, or to formulary management or other PBM services could also reduce the discounts or rebates we receive. In addition, changes in federal or state laws or regulations or the adoption of new laws or regulations relating to claims processing and billing, including our ability to use MAC lists and collect transmission fees, could adversely impact our profitability.

Our retail pharmacy, specialty pharmacy and LTC pharmacy operations have also been affected by the margin pressures described above, including client demands for lower prices, generic pricing and network reimbursement pressure. In addition, as competition increases in the markets in which we operate, a significant increase in general pricing pressures could occur, and this could require us to reevaluate our pricing structures to remain competitive. A shift in the mix of our pharmacy prescription volume towards programs offering lower reimbursement rates could adversely affect our margins, including the shift in pharmacy mix towards 90-day prescriptions at retail and the shift in pharmacy mix towards Medicare Part D prescriptions. Finally, the margins of our LTC business are further affected by the increased efforts of health care payors to negotiate reduced or capitated pricing arrangements. These actions could also adversely affect the margins of our LTC business.

Efforts to reduce reimbursement levels and alter health care financing practices.

The continued efforts of health maintenance organizations, managed care organizations, PBMs, government entities, and other third party payors to reduce prescription drug costs and pharmacy reimbursement rates, as well as litigation and other legal proceedings relating to how drugs are priced, may impact our profitability. In particular, increased utilization of generic pharmaceuticals (which normally yield a higher gross profit rate than equivalent brand named drugs) has resulted in pressure to decrease reimbursement payments to retail, specialty, LTC and mail order pharmacies for generic drugs, causing a reduction in the generic profit rate. Historically, the effect of this trend on generic profitability has been mitigated by our efforts to negotiate reduced acquisition costs of generic pharmaceuticals with manufacturers. However, in recent years, there has been significant consolidation within the generic manufacturing industry, and it is possible that this and other external factors may enhance the ability of manufacturers to sustain or increase pricing of generic pharmaceuticals and diminish our ability to negotiate reduced acquisition costs. Any inability to offset increased costs or to modify our activities to lessen the impact could have a significant adverse effect on our results of operations.

In addition, during the past several years, the United States health care industry has been subject to an increase in governmental regulation and audits at both the federal and state levels. Efforts to control health care costs, including prescription drug costs, are continuing at the federal and state government levels. Changing political, economic and regulatory influences may significantly affect health care financing and reimbursement practices. For example, we anticipate that federal and state governments will continue to review and assess alternative health care delivery systems, payment methodologies and operational requirements for health care providers, including LTC facilities and pharmacies. A change in the composition of pharmacy prescription volume toward programs offering lower reimbursement rates could negatively impact our profitability. Any action taken to repeal or replace all or significant parts of ACA could also impact our profitability, though it is unclear at this time what the full effects will be.

ACA made several significant changes to Medicaid rebates and to reimbursement. One of these changes was to revise the definition of the Average Manufacturer Price, a pricing element common to most payment formulas, and the reimbursement formula for multi-source (i.e., generic) drugs. This change has negatively affected our reimbursement. In addition, ACA made other changes that affect the coverage and plan designs that are or will

be provided by many of our health plan clients, including the requirement for health insurers to meet a minimum medical loss ratio to avoid having to pay rebates to enrollees. These ACA changes may not affect our business directly, but they could indirectly impact our services and/or business practices.

A highly competitive business environment.

Each of our retail pharmacy, LTC pharmacy, retail health clinic and pharmacy services operations currently operates in a highly competitive and evolving health care environment.

The competitive success of our retail pharmacy business, as well as our specialty pharmacy operations with non-Caremark payors, is derived by their ability to establish and maintain contractual relationships with PBMs and other payors on acceptable terms in an environment where some PBM clients are considering adopting narrow or restricted retail pharmacy networks. As a pharmacy retail business, we compete with other drugstore chains, supermarkets, on-line and other discount retailers, independent pharmacies, membership clubs, convenience stores and mass merchants, some of which are aggressively expanding into markets we serve. We also face competition from other retail health clinics, as well as other mail order pharmacies and PBMs. Disruptive innovation by existing or new competitors could alter the competitive landscape in the future and require us to accurately identify and assess such changes and make timely and effective changes to our strategies and business model to compete effectively. Competition may also come from other sources in the future. Changes in market dynamics or the actions of competitors or manufacturers, including industry consolidation, the emergence of new competitors and strategic alliances, and the exclusion from new narrow or restricted networks, could materially and adversely impact us.

We could also be adversely affected if we fail to identify or effectively respond to changes in market dynamics. For example, specialty pharmacy represents a significant and growing proportion of prescription drug spending in the United States, a significant portion of which is dispensed outside of traditional retail pharmacies. Because our specialty pharmacy operations focuses on complex and high-cost medications that serve a relatively limited universe of patients, the future growth of this business depends to a significant extent upon expanding our ability to access key drugs and successfully penetrate key treatment categories.

The competitive success of our LTC pharmacy operations is dependent upon our ability to compete in each geographic region where we have operations. In the geographic regions we serve, we compete with PharMerica, our largest competitor, as well as with numerous local and regional institutional pharmacies, pharmacies owned by long-term care facilities and local retail pharmacies. Our long-term care customers consist of skilled nursing facilities, assisted living facilities, independent living communities, hospitals, correctional facilities, and other health care service providers. We believe that the assisted living segment, where residents can choose which pharmacy will provide them with pharmaceuticals, is projected to grow the most as a percentage of the total LTC sector over the near term. The ability of a resident of an assisted living facility to select the pharmacy that supplies him or her with pharmaceuticals could adversely affect our business, financial condition and results of operations because there can be no assurance that such resident will select us.

The competitive success of our pharmacy services business is impacted by its ability to establish and maintain contractual relationships with network pharmacies in an environment where some PBM clients are considering adopting narrow or restricted retail pharmacy networks. Competitors in the PBM industry (e.g., Express Scripts, OptumRx, Prime Therapeutics, MedImpact and Humana), include large, national PBM companies, PBMs owned by large national health plans and smaller standalone PBMs. Competition may also come from other sources in the future. In addition, changes in the overall composition of our pharmacy networks, or reduced pharmacy access under our networks, could adversely affect our claims volume and/or our competitiveness generally.

Competitors in each of our business areas may offer services and pricing terms that we may not be willing or able to offer. Strong competition in the PBM marketplace has generated greater client demand for lower pricing, increased revenue sharing and enhanced product and service offerings. Unless we can demonstrate enhanced value to our clients through innovative product and service offerings, particularly in a rapidly changing health care industry, we may be unable to remain competitive.

Changes in U.S. policy, laws and regulations, including reform of the United States health care system.

The results of the November 2016 elections continue to generate some uncertainty with respect to, and could result in, significant changes in legislation, regulation and government policy that could significantly impact our business and the health care and retail industries. While it is not possible to predict whether and when any such changes will occur or what form any such changes may take (including through the use of Executive Orders), specific proposals discussed by the Presidential Administration could have a material adverse effect on our business, liquidity and results of operations include, but are not limited to, immigration policies, the modification of ACA. Other significant changes to health care system legislation or regulation as well as changes with respect to tax and trade policies, tariffs and other government regulations affecting trade between the United States and other countries are also possible.

Potential modification to ACA, significant changes to Medicaid funding or even significant destabilization of the Health Insurance Marketplaces could impact the number of Americans with health insurance and, consequently, prescription drug coverage. Further changes to ACA are possible and we cannot predict the effect, if any, on future changes to ACA, the implementation or failure to implement the outstanding provisions of ACA, or the enactment of new health care system legislation to replace current legislation may have on our retail pharmacy, LTC pharmacy, specialty pharmacy and pharmacy services operations.

In addition, much of the branded and generic drug product that we sell in our retail, mail and specialty pharmacies, and much of the other merchandise we sell, is manufactured in whole or in substantial part outside of the United States. In most cases, the products or merchandise are imported by others and sold to us. As a result, significant changes in tax or trade policies, tariffs or trade relations between the United States and other countries, such as the imposition of unilateral tariffs on imported products, could result in significant increases in our costs, restrict our access to suppliers, depress economic activity, and have a material impact on our business, liquidity and results of operations. In addition, other countries may change their business and trade policies and such changes, as well as any negative sentiments towards the United States in response to increased import tariffs and other changes in U.S. trade regulations, could adversely affect our business.

Risks related to compliance with a broad and complex regulatory framework.

Our business is subject to numerous federal, state and local laws and regulations. See "Business - Government Regulation." In addition, during the past several years, the United States health care industry has been subject to an increase in governmental regulation and enforcement activity at both the federal and state levels. Further, uncertainties exist regarding the application of many of these legal requirements to our business. In addition, it is possible that certain provisions of the current health care reform legislation may be modified, repealed or otherwise invalidated. Changes in these laws and regulations and the related interpretations and enforcement practices may require extensive system and operating changes that may be difficult to implement. Untimely compliance or noncompliance with applicable laws and regulations could adversely affect the continued operation of our business, including, but not limited to: imposition of civil or criminal penalties; significant fines or monetary penalties; suspension or disgorgement of payments from government programs; loss of required government certifications or approvals; loss of authorizations to participate in or exclusion from government reimbursement programs, such as the Medicare and Medicaid programs; or loss of registrations or licensure. The regulations to which we are subject include, but are not limited to: the laws and regulations described in the Government Regulation section; accounting standards; financial disclosure; securities laws and regulations; federal anti-trust laws; tax laws and regulations and their possible reform; laws and regulations relating to the protection of the environment and health and safety matters, including those governing exposure to, and the management and disposal of, hazardous materials and wastes; and laws and regulations of the FTC, the FCC, and the Consumer Product Safety Commission, as well as state regulatory authorities, governing the sale, advertisement and promotion of products that we sell, such as Boards of Pharmacy. The FDA, DEA and various states regulate the distribution of pharmaceuticals and controlled substances. We are required to hold valid DEA and state-level registrations and licenses, meet various security and operating standards and comply with the federal and various states' controlled substances acts and their accompanying regulations governing the sale, marketing, packaging, holding and distribution of controlled substances. The DEA, FDA and state regulatory authorities have broad enforcement powers, including the ability to suspend our registrations and licenses, seize or recall products and impose significant criminal, civil and administrative sanctions for violations of these laws and regulations. In addition, our business interests outside of the United States are subject to the Foreign Corrupt Practices Act and other applicable domestic and international laws and regulations. We are also subject to the terms of various government agreements and mandates, including those described in the Government Regulation section. In that regard, our business, financial position and results of operations could be adversely affected by existing and new government legislative, regulatory action and enforcement activity, including, without limitation, any one or more of the following:

- federal and state laws and regulations concerning the submission of claims for reimbursement by Medicare, Medicaid and other government programs, whether at retail, mail, specialty or LTC;
- federal and state laws and regulations governing the purchase, distribution, tracking, management, compounding, dispensing and reimbursement of prescription drugs and related services, whether at retail, mail, specialty or LTC, and applicable registration or licensing requirements;
- heighted enforcement of controlled substances regulations;
- the effect of the expiration of patents covering brand name drugs and the introduction of generic products;

- the frequency and rate of approvals by the FDA of new brand name and generic drugs, or of over-the-counter status for brand name drugs;
- rules and regulations issued pursuant to HIPAA and the HITECH Act; and other federal and state laws affecting the collection, use, disclosure and transmission of health or other personal information, such as federal laws on information privacy precipitated by concerns about information collection through the Internet, state security breach laws and state laws limiting the use and disclosure of prescriber information;
- health care fraud and abuse laws regulations;
- consumer protection laws affecting our health care services, our loyalty programs, our drug discount card programs, the products we sell, the informational calls we make and/or the marketing of our goods and services;
- federal, state and local environmental, health and safety laws and regulations applicable to our business, including the management of hazardous substances, storage and transportation of hazardous materials, and various recordkeeping disclosure and procedure requirements promulgated by the Occupational Safety and Health Administration that may apply to our operations;
- health care reform, managed care reform and plan design legislation;
- laws against the corporate practice of medicine;
- FDA regulation affecting the retail, LTC, specialty or PBM industry;
- government regulation of the development, administration, review and updating of formularies and drug lists including requirements and/or limitations around formulary tiering and patient cost sharing;
- state laws and regulations related to increased oversight of PBM activities by state departments of insurance pharmacy reimbursement for generics and pharmacy audits;
- drug pricing legislation, including “most favored nation” pricing;
- federal and state laws and regulations establishing or changing prompt payment requirements for payments to retail pharmacies;
- impact of network access legislation or regulations, including “any willing provider” laws, on our ability to manage pharmacy networks;
- ERISA and related regulations;
- administration of Medicare Part D, including legislative changes and/or CMS rulemaking and interpretation;
- Medicare and Medicaid regulations applicable to our business, in particular our LTC pharmacies and those of our client’s facilities;
- ongoing compliance with consent decrees, corporate integrity agreements, corrective action plans and other agreements with government agencies;
- insurance licensing and other insurance regulatory requirements applicable to offering Medicare Part D programs and services or other health care services; and
- direct regulation of pharmacies or PBMs by regulatory and quasi-regulatory bodies.

The possibility of client losses and/or the failure to win new business.

Our PBM business generates net revenues primarily by contracting with clients to provide prescription drugs and related health care services to plan members. PBM client contracts often have terms of approximately three years in duration, so approximately one third of a PBM’s client base typically is subject to renewal each year. In some cases, however, PBM

clients may negotiate a shorter or longer contract term or may require early or periodic renegotiation of pricing prior to expiration of a contract. Our clients are generally well informed and organized, can move between our competitors and often seek competing bids prior to expiration of their contracts. In addition, the reputational impact of a service-related incident could negatively affect our business. These factors, together with the impact of competitive pressures, could make it difficult for us to attract new clients, retain existing clients and cross-sell additional services. Further, the PBM industry has been affected by consolidation activity that may continue in the future. In the event one or more of our PBM clients is acquired by an entity that is not also our client, we may be unable to retain all or a portion of the acquired business. These circumstances, either individually or in the aggregate, could result in an adverse effect on our business and financial results. Therefore, we continually face challenges in competing for new PBM business and retaining or renewing our existing PBM business. With respect to our LTC business, reimbursement from skilled nursing facilities for prescriptions we dispense is determined pursuant to our agreements with those skilled nursing facilities. The termination of these agreements generally causes our ability to provide services to any of the residents of that facility to cease, resulting in the loss of revenue from any source for those residents. There can be no assurance that we will be able to win new business or secure renewal business on terms as favorable to us as the present terms.

Additionally, with respect to our retail and LTC pharmacy businesses, reimbursement under Medicare Part D, as well as reimbursement from certain private third-party payors, is determined pursuant to agreements that we negotiate with those payors or their pharmacy benefit manager representatives. The loss of those agreements, or a material change in the terms of those agreements, could negatively impact the Company. In addition, restricted networks that exclude our retail or specialty pharmacies negatively impact those businesses.

Risks relating to the market availability, suppliers and safety profiles of prescription drugs that we purchase and sell.

We dispense significant volumes of brand-name and generic drugs from our retail, LTC, specialty and mail-order pharmacies and through our PBM's network of retail pharmacies. When increased safety risk profiles or manufacturing or other supply issues of specific drugs or classes of drugs occur, or drugs become subject to greater restrictions as controlled substances, physicians may cease writing prescriptions for these drugs or the utilization of these drugs may be otherwise reduced.

Additionally, adverse publicity regarding drugs with higher safety risk profiles may result in reduced consumer demand for such drugs. On occasion, products are withdrawn by their manufacturers or transition to over-the-counter products, which can result in lower prescription utilization. In addition, future FDA rulings could restrict the supply or increase the cost of products sold to our customers. Our volumes, net revenues, profitability and cash flows may decline as a result of such regulatory rulings or market changes.

Further, we acquire a substantial amount of our mail and specialty pharmacies' prescription drug supply from a limited number of suppliers. Our agreements with these suppliers are often short-term and easily cancelable by either party without cause. In addition, these agreements may limit our ability to provide services for competing drugs during the term of the agreement and may allow the supplier to distribute through channels other than ours. Certain of these agreements also allow pricing and other terms to be adjusted periodically for changing market conditions or required service levels. A termination or modification to any of these relationships could have a material adverse effect on our business, financial condition and results of operations. Moreover, many products distributed by our specialty pharmacy business are manufactured with ingredients that are susceptible to supply shortages. In some cases, we depend upon a single source of supply.

In addition, our suppliers are independent entities subject to their own operational and financial risks that are outside our control. If our current suppliers were to stop selling prescription drugs to us or delay delivery, including as a result of supply shortages, supplier production disruptions, supplier quality issues, closing or bankruptcies of our suppliers, or for other reasons, we may be unable to procure alternatives from other suppliers in a timely and efficient manner and on acceptable terms, or at all.

A disruption in our business operations could occur as a result of contamination of drugs, a failure to maintain necessary shipment and storage conditions, errors in mail order processing, the unavailability of prescription drugs provided by suppliers, labor disruptions or other unanticipated disruptions at our mail order facilities, call centers, data centers or corporate facilities, among other factors. Such disruption could reduce our ability to process and dispense prescriptions and provide products and services to our customers.

In the event any products we distribute are in limited supply for significant periods of time, our financial condition and results of operations could be materially and adversely affected.

Risks related to the frequency and rate of the introduction and pricing of generic drugs and brand name prescription products.

The profitability of our business is dependent upon the utilization of prescription drug products. Utilization trends are affected by, among other factors, the introduction of new and successful prescription pharmaceuticals as well as lower-priced generic alternatives to existing brand name products, as the sale of generic alternatives normally yield higher gross

margins than brand name equivalents. In addition, inflation in the price of the brand name drugs can affect utilization, particularly given the increase in high deductible health plans. Accordingly, our business could be impacted by a slowdown or delay in the number or magnitude of new and successful prescription pharmaceuticals and/or generic alternatives, as well as the pricing of brand name drugs.

The health of the economy in general and in the markets we serve.

Our business is affected by the economy and consumer confidence in general, including various economic factors, inflation and changes in consumer purchasing power, preferences and/or spending patterns. It is possible that an unfavorable, uncertain or volatile economic environment will cause a decline in drug and health care services utilization and dampen demand for pharmacy benefit management services as well as consumer demand for products sold in our retail stores. Further economic conditions including interest rate fluctuations, changes in capital market conditions and regulatory changes may affect our ability to obtain necessary financing on acceptable terms, our ability to secure suitable store locations under acceptable terms and our ability to execute sale-leaseback transactions under acceptable terms. These changes in conditions could result in an adverse effect on our business and financial results. This could be further exacerbated by the increasing prevalence of high deductible health plans and health plan designs favoring co-insurance over co-payments.

The failure or disruption of our information technology systems, our information security systems and our infrastructure to support our business and to protect the privacy and security of sensitive customer and business information.

Many aspects of our operations are dependent on our information systems and the information collected, processed, stored, and handled by these systems. We rely heavily on our computer systems to manage our ordering, pricing, point-of-sale, pharmacy fulfillment, inventory replenishment, claims processing, ExtraCare customer loyalty program, finance, human resource and other processes. Throughout our operations, we receive, retain and transmit certain confidential information, including PII that our customers and clients provide to purchase products or services, enroll in programs or services, register on our websites, interact with our personnel, or otherwise communicate with us. In addition, for these operations, we depend in part on the secure transmission of confidential information over public networks. Our information systems are subject to damage or interruption from power outages, facility damage, computer and telecommunications failures, computer viruses, security breaches including credit card or personally identifiable information breaches, coordinated cyber attacks, vandalism, catastrophic events and human error. Although we deploy a layered approach to address information security threats and vulnerabilities, including ones from a cyber security standpoint, designed to protect confidential information against data security breaches, a compromise of our information security controls or of those businesses with whom we interact, which results in confidential information being accessed, obtained, damaged, or used by unauthorized or improper persons, could harm our reputation and expose us to regulatory actions and claims from customers and clients, financial institutions, payment card associations and other persons, any of which could adversely affect our business, financial position, and results of operations. Because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may not immediately produce signs of intrusion, we may be unable to anticipate these techniques or to implement adequate preventative measures. Moreover, a data security breach could require that we expend significant resources related to our information systems and infrastructure, and could distract management and other key personnel from performing their primary operational duties. We also could be adversely affected by any significant disruption in the systems of third parties we interact with, including key payors and vendors.

If our information systems are damaged, fail to work properly or otherwise become unavailable, or if we are unable to successfully complete our planned consolidation of our PBM claims adjudication platforms, we may incur substantial costs to repair or replace them, and may experience reputational damage, loss of critical information, customer disruption and interruptions or delays in our ability to perform essential functions and implement new and innovative services. In addition, compliance with changes in privacy and information security laws and standards may result in considerable expense due to increased investment in technology and the development of new operational processes.

Failure to adequately protect receipt and use of confidential health information concerning individuals.

Many aspects of our business involve the collection, transmission and use of an individual's protected health information or other sensitive personal information. In some cases, we also use aggregated and de-identified data as defined by HIPAA for analytical and research purposes, particularly data related to improving the quality of the care we provide. In other cases, we may provide de-identified data to pharmaceutical manufacturers and to third-party data aggregators where permitted by our contracts. These activities are subject to federal and state privacy and security laws and regulations and, in the future, may be subject to international regulatory requirements such as the General Data Protection Regulation, a new European Union privacy regulation that takes effect on May 25, 2018. At the federal level, HIPAA imposes extensive privacy and security requirements governing the transmission, use and disclosure of health

information by all participants in the health care industry, whether directly as a covered entity or as a business associate. Our business encompasses both situations and includes our pharmacists, nurse practitioners and PBM operations. In addition, industry requirements, such as Generally Accepted Privacy Principles may be imposed on us by our contracts with our PBM clients or other customers. Many of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a security standard mandated by the credit card industry for the purpose of protecting credit card account data. These increasingly complex laws, regulations and industry requirements are subject to change and compliance with them may result in significant expenses associated with increased operational and compliance costs, particularly as we continue to collect and retain large amounts of information. To the extent that either we or our vendors with whom we share information are found to be out of compliance with applicable laws and regulations or experience a data security breach, we could be subject to additional litigation, regulatory risks and reputational harm. For example, the privacy and security of the information we maintain may be compromised by the actions of outside parties, by employee errors or by malfeasance. Such risks may result in an unauthorized party obtaining access to our data systems thereby threatening the privacy of protected health information or other sensitive personal information we use and maintain. Failure to comply with federal or state statutes or regulations may result in criminal penalties and civil sanctions. In addition, failure to comply with our own privacy or security policies may result in sanctions by the FTC or other federal oversight agencies. Future regulations and legislation that severely restrict or prohibit our use of patient, member or customer identifiable or other information could limit our ability to use information critical to the operation of our business. Furthermore, if we violate a patient's privacy or are found to have violated any federal or state statute or regulation with regard to confidentiality or dissemination or use of PHI, we could be liable for significant damages, fines or penalties and suffer reputational harm, any one of which could have a material adverse effect on our business and results of operations.

Regulatory and business changes relating to our participation in Medicare Part D.

Medicare Part D has resulted in increased utilization and puts pressure on pharmacy gross margin rates due to regulatory and competitive pressures. Further, as a result of ACA and changes to the retiree drug subsidy rules, our PBM clients could decide to discontinue providing prescription drug benefits to their Medicare-eligible members. To the extent this occurs, the adverse effects of increasing customer migration into Medicare Part D may outweigh the benefits we realize from growth of our Medicare Part D business. In addition, if the cost and complexity of Medicare Part D exceed management's expectations or prevent effective program implementation or administration; if changes to the regulations regarding how drug costs are reported for Medicare Part D are implemented in a manner that impacts the profitability of our Medicare Part D business; if changes to the regulations impact our ability to retain fees from third parties including network pharmacies; if the government alters Medicare program requirements or reduces funding because of the higher-than-anticipated cost to taxpayers of Medicare Part D or for other reasons; if the government mandates the use of point-of-sale manufacturer rebates or makes changes to how pharmacy pay-for-performance is calculated; if Congress acts to reduce reinsurance thresholds from 80% to 20%; if we fail to design and maintain programs that are attractive to Medicare participants; if CMS imposes restrictions on our Medicare Part D business as a result of audits or other regulatory actions; if we fail to successfully implement corrective action or other remedial measures sufficient to prevent or remove any applicable restrictions that may be imposed by CMS; or if we are not successful in retaining enrollees, or winning contract renewals or new contracts under Medicare Part D's competitive bidding process, our Medicare Part D services and the ability to expand our Medicare Part D services could be negatively impacted.

Possible changes in industry pricing benchmarks and drug pricing generally.

It is possible that the pharmaceutical industry or regulators may evaluate and/or develop an alternative pricing reference to replace Average Wholesale Price ("AWP") or Wholesale Acquisition Cost ("WAC"), which are the pricing references used for many of our PBM and LTC client contracts, pharmaceutical purchase agreements, retail network contracts, specialty payor agreements and other contracts with third party payors in connection with the reimbursement of drug payments. In addition, many state Medicaid fee-for-service programs

("FFS Medicaid") have established pharmacy network payments on the basis of Actual Acquisition Cost ("AAC"). The use of an AAC basis in FFS Medicaid could have an impact in reimbursement practices in other commercial and government segments. Future changes to the use of AWP, WAC or to other published pricing benchmarks used to establish pharmaceutical pricing, including changes in the basis for calculating reimbursement by federal and state health programs and/or other payors, could impact the reimbursement we receive from Medicare and Medicaid programs, the reimbursement we receive from PBM clients and other payors and/or our ability to negotiate rebates and/or discounts with pharmaceutical manufacturers, wholesalers, PBMs and retail pharmacies. A failure or inability to fully offset any increased prices or costs or to modify our operations to mitigate the impact of such increases could have an adverse effect on our results of operations.

Additionally, any future changes in drug prices could be significantly different than our projections. The effect of these possible changes on our business cannot be predicted at this time.

Product liability, product recall or personal injury issues could damage our reputation; failure to maintain adequate liability insurance coverage.

The products that we sell could become subject to contamination, product tampering, mislabeling, recall or other damage. In addition, errors in the dispensing and packaging of pharmaceuticals could lead to serious injury or death. Product liability or personal injury claims may be asserted against us with respect to any of the products or pharmaceuticals we sell or services we provide. Our business involves the provision of professional services including by pharmacists, nurses and nurse practitioners that exposes us to professional liability claims. Should a product or other liability issue arise, the coverage limits under our insurance programs and the indemnification amounts available to us may not be adequate to protect us against claims. We also may not be able to maintain this insurance on acceptable terms in the future. Damage to our reputation in the event of a product liability or personal injury issue or judgment against us or a product recall could have a significant adverse effect on our business, financial condition and results of operations.

Relationship with our retail and specialty pharmacy customers and the demand for our products and services, including propriety brands.

The success of our business depends in part on customer loyalty, superior customer service and our ability to persuade customers to frequent our retail stores and online sites and to purchase products in additional categories and our proprietary brands. Failure to timely identify or effectively respond to changing consumer preferences and spending patterns, and evolving demographic mixes in our markets, an inability to expand the products being purchased by our clients and customers, or the failure or inability to obtain or offer particular categories of products could negatively affect our relationship with our clients and customers and the demand for our products and services and could result in excess inventories of products.

We offer our retail customers proprietary brand products that are available exclusively at our retail stores and through our online retail sites. The sale of proprietary products subjects us to unique risks including potential product liability risks and mandatory or voluntary product recalls, potential supply chain and distribution chain disruptions for raw materials and finished products, our ability to successfully protect our intellectual property rights and the rights of applicable third parties, and other risks generally encountered by entities that source, market and sell private-label products. Any failure to adequately address some or all of these risks could have an adverse effect on our business, results of operations and financial condition. Additionally, an increase in the sales of our proprietary brands may negatively affect our sales of products owned by our suppliers which, consequently, could adversely impact certain of our supplier relationships. Our ability to locate qualified, economically stable suppliers who satisfy our requirements, and to acquire sufficient products in a timely and effective manner, is critical to ensuring, among other things, that customer confidence is not diminished. Any failure to develop sourcing relationships with a broad and deep supplier base could adversely affect our financial performance and erode customer loyalty.

Finally, our specialty pharmacy business focuses on complex and high-cost medications, many of which are made available by manufacturers to a limited number of pharmacies (so-called limited distribution drugs), that serve a relatively limited universe of patients. As a result, the future growth of our specialty pharmacy business is dependent largely upon expanding our base of drugs or penetration in certain treatment categories. Any contraction of our base of patients or reduction in demand for the prescriptions we currently dispense could have an adverse effect on our business, financial condition and results of operations.

Risks related to developing and maintaining a relevant omni-channel experience for our customers.

Our business has evolved from a retail store experience to interaction with customers across numerous channels, including in-store, online, mobile and social media, among others. Omni-channel retailing is rapidly evolving and we must keep pace with changing customer expectations and new developments by our competitors. Our customers are increasingly using computers, tablets, mobile phones, and other devices to comparison shop, determine product availability and complete purchases through mobile commerce applications. As a result, the portion of total consumer expenditures with all retailers occurring online and through mobile commerce applications is increasing and the pace of this increase could accelerate. We must compete by offering a consistent and convenient shopping experience for our customers regardless of the ultimate sales channel and by investing in, providing and maintaining mobile commerce

applications for our customers that have the right features and are reliable and easy to use. If we are unable to make, improve, or develop relevant customer-facing technology in a timely manner that keeps pace with technological developments and dynamic customer expectations, our ability to compete and our results of operations could be materially and adversely affected. In addition, if our online activities or our other customer-facing technology systems do not function as designed, we may experience a loss of customer confidence, data security breaches, lost sales, or be exposed to fraudulent purchases, any of which could materially and adversely affect our business operations, reputation and results of operations.

We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.

We accept payments using a variety of methods, including cash, checks, credit cards, debit cards, gift cards, mobile payments and potentially other technologies in the future. Acceptance of these payment methods subjects us to rules, regulations, contractual obligations and compliance requirements, including payment network rules and operating guidelines, data security standards and certification requirements, and rules governing electronic funds transfers. These requirements may change in the future, which could make compliance more difficult or costly. For certain payment options, including credit and debit cards, we pay interchange and other fees, which could increase periodically thereby raising our operating costs. We rely on third parties to provide payment processing services, including the processing of credit cards, debit cards, and various other forms of electronic payment. If these companies are unable to provide these services to us, or if their systems are compromised, our operations could be disrupted. The payment methods that we offer also expose us to potential fraud and theft by persons seeking to obtain unauthorized access to, or exploit any weaknesses in, the payment systems. If we fail to abide by applicable rules or requirements, or if data relating to our payment systems is compromised due to a breach or misuse, we may be responsible for any costs incurred by payment card issuing banks and other third parties or subject to fines and higher transaction fees. In addition, our reputation and ability to accept certain types of payments could each be harmed resulting in reduced sales and adverse effects on our results of operations.

Solvency of our customers.

In the event that our customers' operating and financial performance deteriorates, or they are unable to make scheduled payments or obtain adequate financing, our customers may not be able to pay timely, or may delay payment of, amounts owed to us. Any inability of our customers to pay us for our products and services may adversely affect our business, financial condition and results of operations. In addition, both state and federal government sponsored payers, as a result of budget deficits or reductions, may suspend payments or seek to reduce their healthcare expenditures resulting in our customers delaying payments to us or renegotiating their contracts with us. Any delay or reduction in payments by such government sponsored payers may adversely affect our business, financial condition and results of operations.

Our outstanding debt and associated payment obligations could significantly increase in the future if we incur additional debt and do not retire existing debt.

Our current debt service costs associated with our increased debt levels may negatively impact our ability to make important investments in our business and limit our flexibility to respond to industry changes and market conditions. In addition, our debt levels and related debt service obligations could make it more difficult or expensive for us to obtain financing for working capital, capital expenditures, acquisitions or other purposes in the future. These circumstances could have a material adverse effect on our business operations and financial condition.

Further, we may incur and assume significantly more debt in the future, including in connection with the Aetna Acquisition or other acquisitions, strategic investments or joint ventures. For example, in connection with the Aetna Acquisition, if it is completed, we expect to incur approximately, $45.0 billion of new indebtedness and assume approximately $8.2 billion of existing indebtedness of Aetna. If we do not retire our existing debt or debt we

assume in acquisitions or other strategic transactions, the risks described above could increase. We also could be adversely impacted by any failure to renew or replace, on terms acceptable to us or at all, existing indebtedness when it expires, and by any failure to satisfy applicable covenants.

We may be unable to refinance existing indebtedness or otherwise access the capital markets for any reason, whether due to market conditions or otherwise. Our continued access to the capital markets, and the terms of such access, depend on multiple factors including the condition of debt capital markets, our operating performance, the amount of our

indebtedness and debt service obligations and our credit ratings. Any disruptions or turmoil in the capital markets or any downgrade of our credit ratings could have a material adverse effect on our cost of funds, liquidity, competitive position and access to capital markets, which could materially and adversely affect our business operations, financial condition, and results of operations.

Our long-term debt obligations include covenants that limit our ability and the ability of our subsidiaries to secure indebtedness with a security interest on certain property or stock or engage in certain sale and leaseback transactions with respect to certain properties. In addition, our existing credit agreements require us to maintain a ratio of consolidated debt to total capitalization not to exceed specified levels. Our ability to comply with these restrictions and covenants may be affected by events beyond our control, and if we fail to comply with such restrictions or covenants, our outstanding indebtedness could be declared immediately due and payable. This could have a material adverse effect on our business operations and financial condition.

We may be unable to successfully integrate companies acquired by us.

Upon the closing of any acquisition we complete, we will need to successfully integrate the products, services and related assets, as well as internal controls into our business operations. If an acquisition is consummated, the integration of the acquired business, its products, services and related assets into our company may also be complex and time-consuming and, if the integration is not fully successful, we may not achieve the anticipated benefits, operating and cost synergies or growth opportunities of an acquisition. Potential difficulties that may be encountered in the integration process include the following:

- Integrating personnel, operations and systems, while maintaining focus on producing and delivering consistent, high quality products and services;
- Coordinating geographically dispersed organizations;
- Disruption of management's attention from our ongoing business operations;
- Retaining existing customers and attracting new customers; and
- Managing inefficiencies associated with integrating our operations.

An inability to realize the full extent of the anticipated benefits, operating and cost synergies, innovations and operations efficiencies or growth opportunities of an acquisition, as well as any delays encountered in the integration process, could have a material adverse effect on our business and results of operation. Furthermore, these acquisitions, even if successfully integrated, may fail to further our business strategy as anticipated, expose us to increased competition or challenges with respect to our products, services or geographic markets, and expose us to additional liabilities associated with an acquired business including risks and liabilities associated with litigation involving the acquired business. Any one of these challenges or risks could impair our ability to realize any benefit from our acquisitions after we have expended resources on them.

Risks related to the seasonality of our business.

Although the majority of our revenues, particularly pharmacy revenues, are generally not seasonal in nature, front store revenues tend to be higher during the December holiday season. Uncharacteristic or extreme weather conditions can adversely impact consumer shopping patterns as well. This could lead to lost sales, as well as increased snow removal and other costs, thereby negatively affecting our short-term results of operations. In addition, both pharmacy and front store revenues are affected by the timing and severity of the cough, cold and flu season, which is susceptible to large fluctuations from year to year, and our quarterly earnings and operating cash flows are impacted by the Medicare Part D benefit design and changes in the composition of our membership. See "Business - Pharmacy Services Seasonality."

Our operations are subject to a variety of business continuity hazards and risks, any of which could interrupt operations or otherwise adversely affect our performance and results.

We are subject to business continuity hazards and other risks, including natural disasters, utility and other mechanical failures, acts of war or terrorism, disruption of communications, data security and preservation, disruption of supply or distribution, safety regulation and labor difficulties. The occurrence of any of these or other events might disrupt or shut down operations, or otherwise adversely impact our operations. We may also be subject to certain liability claims in the event of an injury or loss of life, or damage to property, resulting from such events. Although we have developed business continuity plans and maintain insurance policies that we believe are customary and adequate for our size and

industry, our insurance policies include limits and, as such, our coverage may be insufficient to protect against all potential hazards and risks incident to our business. Should any such hazards or risks occur, or should our insurance coverage be inadequate or unavailable, our business financial condition and results of operations could be adversely affected.

Risks related to litigation and other legal proceedings.

Pharmacy services, retail pharmacy and LTC pharmacy are highly regulated and litigious industries. We are currently subject to various litigation matters, investigations, audits, inspections, government inquiries, and regulatory and legal proceedings. Litigation, and particularly securities and collective or class action litigation, is often expensive and disruptive. Further, under the *qui tam* or "whistleblower" provisions of the federal and various state false claims acts, private citizens may bring lawsuits alleging that a violation of the federal anti-kickback statute or similar laws has resulted in the submission of "false" claims to federal and/or state health care programs, including Medicare and Medicaid. Litigation related to our provision of professional services in our pharmacies, specialty pharmacies, clinics and LTC facilities has also increased as we expand our services along the continuum of health care. We cannot predict the outcome of any of these matters, and the costs incurred may be substantial regardless of outcome. Our business, financial condition and results of operations may be adversely affected, or we may be required to materially change our business practices, as a result of such proceedings. We refer you to Item 3, "Legal Proceedings" for additional information.

We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success, and our failure to do so could have an adverse impact on our future performance.

Our ability to attract and retain qualified and experienced employees is essential to meet current and future goals and objectives and there is no guarantee we will be able to attract and retain such employees or that competition among potential employers will not result in increased salaries or other benefits. An inability to retain existing employees or attract additional employees, or an unexpected loss of leadership, could have a material adverse effect on our business and results of operations.

In addition, our failure to adequately plan for succession of senior management and other key management roles or the failure of key employees to successfully transition into new roles could have a material adverse effect on our business and results of operations. While we have succession plans in place and employment arrangements with certain key executives, these do not guarantee the services of these executives will continue to be available to us.

Goodwill and other intangible assets could, in the future, become impaired.

As of December 31, 2017, we had $52.1 billion of goodwill and other intangible assets. Goodwill and indefinitely-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable. When evaluating goodwill for potential impairment, we first compare the fair value of our reporting units to their respective carrying amounts. We estimate the fair value of our reporting units using a combination of a discounted cash flow model and a comparable market multiple model. If the estimated fair value of the reporting unit is less than its carrying amount, an impairment loss calculation is prepared. The impairment loss calculation compares the fair value of a reporting unit to its carrying amount. If the carrying amount of the reporting unit exceeds the fair value, a goodwill impairment loss is recognized in an amount equal to the excess to the extent of the goodwill balance. Estimated fair values could change if, for example, there are changes in the business climate, changes in the competitive environment, adverse legal or regulatory actions or developments, changes in capital structure, cost of debt, interest rates, capital expenditure levels, operating cash flows, or market capitalization. Because of the significance of our goodwill and intangible assets, any future impairment of these assets could require material noncash charges to our results of operations, which could have a material adverse effect on our financial condition and results of operations.

The foregoing is not a comprehensive listing of all possible risks and there can be no assurance that we have correctly identified and appropriately assessed all factors affecting the business. As such, we refer you to "Management's Discussion and Analysis of Financial Condition and Results of Operations," which includes our "Cautionary Statement Concerning Forward-Looking Statements" at the end of such section, of our Annual Report to Stockholders for the year ended December 31, 2017, which section is incorporated by reference herein.

Aetna-Related Risk Factors In addition to the risk factors described above that could materially adversely affect our business, financial condition, results of operations, cash flows and prospects, the following risk factors, and additional risks not presently known to us or that we currently deem to be immaterial, could also materially adversely affect us and the Aetna Acquisition.

In order to complete the merger, we and Aetna must obtain certain governmental authorizations, and if such authorizations are not granted or are granted with conditions that become applicable to the parties, completion of the merger may be jeopardized or prevented or the anticipated benefits of the merger could be reduced.

Completion of the merger is conditioned upon the expiration or early termination of the waiting period relating to the merger under the HSR Act and certain other applicable laws or regulations and the required governmental authorizations having been obtained and being in full force and effect. Although we and Aetna have agreed in the merger agreement to use our reasonable best efforts, subject to certain limitations, to make certain governmental filings or obtain the governmental authorizations required to complete the merger (the "required governmental authorizations"), as the case may be, there can be no assurance that the relevant waiting periods will expire or authorizations will be obtained and no assurance that the merger will be completed.

In addition, the governmental authorities from which these authorizations are required have broad discretion in administering the governing laws and regulations, and may take into account various facts and circumstances in their consideration of the merger, including other potential transactions in the health care industry or other industries. These governmental authorities may initiate proceedings seeking to prevent, or otherwise seek to prevent, the merger. As a condition to authorization of the merger or related transactions, these governmental authorities also may impose requirements, limitations or costs, require divestitures or place restrictions on the conduct of our business after completion of the merger. Under the terms of the merger agreement, we are not required, and Aetna is not permitted without our consent, to take any actions or agree to any terms or conditions in connection with (i) the expiration or early termination of the waiting period relating to the merger under the HSR Act, (ii) any other antitrust law or (iii) the required governmental authorizations, in each case if such action, term or condition would have, or would reasonably be expected to have, individually or in the aggregate, a regulatory material adverse effect on us or Aetna.

However, notwithstanding the provisions of the merger agreement, either we or Aetna could become subject to terms or conditions in connection with such waiting periods, laws or other authorizations (whether because such term or condition does not rise to the specified level of materiality or we otherwise consent to its imposition) the imposition of which could adversely affect our ability to integrate Aetna's operations with our operations, reduce the anticipated benefits of the merger or otherwise materially and adversely affect our business and results of operations after completion of the merger.

In addition to receipt of certain governmental authorizations, completion of the merger is subject to a number of other conditions, and if these conditions are not satisfied or waived, the merger will not be completed.

Our obligations and the obligations of Aetna to complete the merger are subject to satisfaction or waiver of a number of conditions in addition to receipt of certain governmental authorizations, including, among other conditions: (i) approval and adoption of the merger agreement by Aetna shareholders at an Aetna special meeting, (ii) approval of the stock issuance by our stockholders at the CVS Health special meeting, (iii) approval for the listing on the New York Stock Exchange of the shares of CVS Health common stock to be issued in the merger, (iv) absence of any applicable law or order that prohibits completion of the transaction, (v) accuracy of the representations and warranties made in the merger agreement by the other party, subject to certain materiality qualifications, (vi) performance in all material respects by the other party of the material obligations required to be performed by it at or prior to completion of the transaction, and (vii) the absence of a material adverse

effect on the other party. There can be no assurance that the conditions to completion of the merger will be satisfied or waived or that the merger will be completed.

In addition, the CVS Health special meeting and the Aetna special meeting may take place before certain governmental authorizations have been obtained and, therefore, before the terms on which such governmental authorizations may be obtained, or the conditions to obtaining such governmental authorizations that may be imposed, are known. As a result, if CVS Health stockholders approve the stock issuance at the CVS Health special meeting, or Aetna shareholders approve and adopt the merger agreement at the Aetna special meeting, we and Aetna may make decisions after the respective meetings to waive a condition as to the receipt of certain governmental authorizations or to take certain

actions required to obtain such governmental authorizations without seeking further stockholder or shareholder approval, as applicable, and such actions could have an adverse effect on the combined company.

After completion of the merger, we may fail to realize the anticipated benefits and cost savings of the merger, which could adversely affect the value of shares of our common stock.

The success of the merger will depend, in part, on our ability to realize the anticipated benefits and cost savings from combining the businesses of CVS Health and Aetna. Our ability to realize these anticipated benefits and cost savings is subject to certain risks, including:

- Our ability to successfully combine the businesses of CVS Health and Aetna;
- whether the combined businesses will perform as expected;
- the possibility that we paid more for Aetna than the value we will derive from the acquisition;
- the reduction of our cash available for operations and other uses and the incurrence of indebtedness to finance the acquisition; and
- the assumption of known and unknown liabilities of Aetna.

If we are not able to successfully combine the businesses of CVS Health and Aetna within the anticipated time frame, or at all, the anticipated cost savings and other benefits of the merger may not be realized fully or may take longer to realize than expected, the combined businesses may not perform as expected and the value of the shares of our common stock may be adversely affected.

We and Aetna have operated and, until completion of the merger will continue to operate, independently, and there can be no assurances that our respective businesses can be integrated successfully. It is possible that the integration process could result in the loss of key CVS Health or Aetna employees, the disruption of either company's or both companies' ongoing businesses or in unexpected integration issues, higher than expected integration costs and an overall post-completion integration process that takes longer than originally anticipated. Specifically, issues that must be addressed in integrating the operations of Aetna and CVS Health in order to realize the anticipated benefits of the merger so the combined business performs as expected include, among other things:

- combining the companies' separate operational, financial, reporting and corporate functions;
- integrating the companies' technologies, products and services;
- identifying and eliminating redundant and underperforming operations and assets;
- harmonizing the companies' operating practices, employee development, compensation and benefit programs, internal controls and other policies, procedures and processes;
- addressing possible differences in business backgrounds, corporate cultures and management philosophies;
- consolidating the companies' corporate, administrative and information technology infrastructure;
- coordinating sales, distribution and marketing efforts;
- managing the movement of certain businesses and positions to different locations;
- maintaining existing agreements with customers, providers and vendors and avoiding delays in entering into new agreements with prospective customers, providers and vendors;

- operating in industry sectors in which we and our current management may have little or no experience;
- coordinating geographically dispersed organizations;
- consolidating offices of Aetna and CVS Health that are currently in or near the same location; and
- effecting potential actions that may be required in connection with obtaining regulatory approvals.

In addition, at times, the attention of certain members of each company's management and each company's resources may be focused on completion of the merger and the integration of the businesses of the two companies and diverted from day-to-day business operations, which may disrupt each company's ongoing business and the business of the combined company.

We have limited experience in the insurance and managed health care industry, which may hinder our ability to achieve the combined company's objectives.

We have limited experience operating an insurance and managed health care business, and will rely in large part on the existing management of Aetna to continue to manage the Aetna business following the merger. However, there is no

assurance that we will be able to retain the services of such management. If we fail to retain the existing management of Aetna, our ability to realize the anticipated benefits of the transaction may be adversely affected.

We and Aetna may have difficulty attracting, motivating and retaining executives and other key employees in light of the merger.

As we will be operating in industry sectors for which our existing management team has little or no experience, our success after the transaction will depend in part on our ability to retain key executives and other employees of Aetna. Uncertainty about the effect of the merger on CVS Health and Aetna employees may have an adverse effect on each of us and Aetna separately and consequently the combined business. This uncertainty may impair our and/or Aetna's ability to attract, retain and motivate key personnel. Employee retention may be particularly challenging during the pendency of the merger, as employees of CVS Health and Aetna may experience uncertainty about their future roles in the combined business.

Additionally, Aetna's officers and employees may hold Aetna common shares, as well as Aetna stock appreciation rights, Aetna restricted stock units ("Aetna RSUs") and Aetna performance stock units ("Aetna PSUs") that are subject to accelerated vesting on a change in control, and, if the merger is completed, these officers and employees may be entitled to cash and/or the consideration payable under the merger agreement in respect of such Aetna common shares, stock appreciation rights, Aetna RSUs and Aetna PSUs. These payouts could also make retention of these officers and employees more difficult. Additionally, pursuant to employment agreements and/or other agreements or arrangements with Aetna, certain key employees of Aetna are entitled to receive severance payments upon a termination without cause and/or a resignation for "good reason" following completion of the merger. Under these agreements, certain key employees of Aetna potentially could resign from his or her employment following specified circumstances set forth in his or her applicable agreement, including an adverse change in his or her title, authority or responsibilities, compensation and benefits or primary office location.

Furthermore, if key employees of CVS Health or Aetna depart or are at risk of departing, including because of issues relating to the uncertainty and difficulty of integration, financial security or a desire not to become employees of the combined business, we may have to incur significant costs in retaining such individuals or in identifying, hiring and retaining replacements for departing employees and may lose significant expertise and talent relating to the business of Aetna, and our ability to realize the anticipated benefits of the merger may be materially and adversely affected. Accordingly, no assurance can be given that we will be able to attract or retain key employees of Aetna to the same extent that Aetna has been able to attract or retain employees in the past.

Our and Aetna's business relationships may be subject to disruption due to uncertainty associated with the merger.

Parties with which we or Aetna do business may experience uncertainty associated with the merger, including with respect to current or future business relationships with us, Aetna or the combined business. Our and Aetna's business relationships may be subject to disruption as customers, providers, vendors and others may attempt to negotiate changes in existing business relationships or consider entering into business relationships with parties other than us, Aetna or the combined business. These disruptions could have a material adverse effect on the businesses, financial condition, results of operations or prospects of CVS Health, Aetna and/or the combined business, including a material adverse effect on our ability to realize the anticipated benefits of the merger. The risk and adverse effect of such disruptions could be exacerbated by a delay in completion of the merger or termination of the merger agreement.

The merger agreement contains provisions that may make it more difficult for us and Aetna to pursue alternatives to the merger.

The merger agreement contains provisions that make it more difficult for Aetna to sell its business to a party other than us, or for us to sell its business. These provisions include a general prohibition on each party soliciting any acquisition proposal. Further, there are only

limited exceptions to each party's agreement that its board of directors will not withdraw or modify in a manner adverse to the other party the recommendation of its board of directors in favor of the approval and adoption of the merger agreement, in the case of Aetna, or the approval of the stock issuance, in our case, and the other party generally has a right to match any acquisition proposal that may be made. However, at any time prior to the approval and adoption of the merger agreement by Aetna shareholders, in the case of Aetna, or the approval of the stock issuance by CVS Health stockholders, in our case, such party's board of directors is permitted to take certain of

these actions if it determines in good faith that the failure to take such action would be reasonably likely to be inconsistent with its fiduciary duties under applicable law.

While we believe these provisions are reasonable and not preclusive of other offers, these restrictions might discourage a third party that has an interest in acquiring all or a significant part of either Aetna or CVS Health from considering or proposing that acquisition, even if that party were prepared to pay consideration with a higher per-share value than the currently proposed merger consideration, in the case of Aetna, or that party were prepared to enter into an agreement that may be favorable to us or our stockholders, in our case. Furthermore, the termination fees described below may result in a potential competing acquirer proposing to pay a lower per-share price to acquire the applicable party than it might otherwise have proposed to pay because of the added expense of the termination fee that may become payable by such party in certain circumstances.

Failure to complete the merger could negatively impact our stock price and our future business and financial results.

If the merger is not completed for any reason, including as a result of Aetna shareholders failing to approve and adopt the merger agreement or CVS Health stockholders failing to approve the stock issuance, our ongoing business may be materially and adversely affected and, without realizing any of the benefits of having completed the merger, we would be subject to a number of risks, including the following:

- we may experience negative reactions from the financial markets, including negative impacts on the trading price of our common stock and other securities, and from our customers, providers, vendors, regulators and employees;
- we may be required to pay Aetna a termination fee of $2.1 billion if the merger agreement is terminated under certain circumstances;
- we will be required to pay certain transaction expenses and other costs incurred in connection with the merger, whether or not the merger is completed;
- the merger agreement places certain restrictions on the conduct of our businesses prior to completion of the merger, and such restrictions, the waiver of which is subject to the consent of Aetna, may prevent us from making certain acquisitions, taking certain other specified actions or otherwise pursuing business opportunities during the pendency of the merger that we would have made, taken or pursued if these restrictions were not in place; and
- matters relating to the merger (including arranging permanent financing and integration planning) will require substantial commitments of time and resources by our management and the expenditure of significant funds in the form of fees and expenses, which would otherwise have been devoted to day-to-day operations and other opportunities that may have been beneficial to us as an independent company.

There can be no assurance that the risks described above will not materialize. If any of those risks materialize, they may materially and adversely affect our businesses, financial condition, financial results, ratings, stock prices and/or bond prices.

In addition, we could be subject to litigation related to any failure to complete the merger or related to any proceeding to specifically enforce our obligation to perform our obligations under the merger agreement. If the merger is not completed, these risks may materialize and may materially and adversely affect our businesses, financial condition, financial results, ratings, stock prices and/or bond prices.

We and Aetna may be targets of securities class action and derivative lawsuits which could result in substantial costs and may delay or prevent the merger from being completed.

Securities class action lawsuits and derivative lawsuits are often brought against public companies that have entered into merger agreements. Even if the lawsuits are without merit, defending against these claims can result in substantial costs and divert management time and resources. An adverse judgment could result in monetary damages, which could have a negative impact on our and Aetna's respective liquidity and financial condition. Additionally, if a plaintiff is successful in obtaining an injunction prohibiting completion of the merger, then that injunction may delay or prevent the merger from being completed, which may adversely affect our and Aetna's respective business, financial position and results of operation. Since the filing with the SEC of the preliminary joint proxy statement/prospectus relating to the proposed merger, a number of class action lawsuits in connection with the merger have been filed against us, Aetna and Aetna's

directors and officers. Neither we nor Aetna presently believe that there is any merit to any such lawsuit. We and Aetna intend to defend them vigorously.

Our indebtedness following completion of the merger will be substantially greater than our indebtedness on a stand-alone basis and greater than the combined indebtedness of CVS Health and Aetna existing prior to the announcement of the transaction. This increased level of indebtedness could adversely affect our business flexibility, and increase our borrowing costs. Downgrades in our ratings could adversely affect our business, cash flows, financial condition and operating results.

In order to complete the merger, we expect to incur acquisition-related debt financing of approximately $45.0 billion and assume Aetna's existing indebtedness of approximately $8.2 billion. Our substantially increased indebtedness and higher debt-to-equity ratio following completion of the merger in comparison to that of CVS Health prior to the merger will have the effect, among other things, of reducing our flexibility to respond to changing business and economic conditions and will increase our borrowing costs. In addition, the amount of cash required to service our increased indebtedness levels and thus the demands on our cash resources will be greater than the amount of cash flows required to service the indebtedness of CVS Health or Aetna individually prior to the merger. The increased levels of indebtedness could also reduce funds available to fund our efforts to combine our business with Aetna and realize expected benefits of the merger and/or engage in investments in product development, capital expenditures, dividend payments, share repurchases and other activities and may create competitive disadvantages for us relative to other companies with lower debt levels.

In addition, our credit ratings impact the cost and availability of future borrowings, and, as a result, our cost of capital. Our ratings reflect each rating organization's opinion of our financial strength, operating performance and ability to meet our debt obligations or, following completion of the merger, obligations to the combined company's insureds. Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future. Following the announcement of the merger agreement, each of Standard & Poor's and Moody's placed certain of our debt, financial strength and other credit ratings under review for a possible downgrade. Following the announcement of the merger agreement, Standard & Poor's, A.M. Best and Fitch placed Aetna's debt, financial strength and other credit ratings under review with negative implications. Downgrades in our ratings could adversely affect our business, cash flows, financial condition and operating results. In addition, if the merger is completed and, in certain circumstances, Aetna's debt securities are rated below investment grade, this may constitute a change of control triggering event under the indentures governing such debt. Upon the occurrence of a change of control triggering event, Aetna, as the surviving corporation of the merger, would be required to offer to repurchase most of Aetna's outstanding notes at 101% of the principal amount thereof plus accrued and unpaid interest if any, to, but not including, the date of repurchase. However, it is possible that Aetna (or us) would not have sufficient funds at the time of the change of control triggering event to make the required repurchase of notes or that restrictions in other debt instruments would not allow such repurchases. We cannot provide any assurance that there will be sufficient funds available for Aetna (or us) to make any required repurchases of the notes upon a change of control triggering event.

We will incur significant transaction and integration-related costs in connection with the merger.

We expect to incur a number of non-recurring costs associated with the merger and combining the operations of the two companies. We will incur significant transaction costs related to the merger, including with respect to the financing for the cash consideration to be paid to Aetna shareholders. We also will incur significant integration-related fees and costs related to formulating and implementing integration plans, including facilities and systems consolidation costs and employment-related costs. We continue to assess the magnitude of these costs, and additional unanticipated costs may be incurred in the merger and the integration of the two companies' businesses. Although we expect that the elimination of duplicative costs, as well as the realization of other efficiencies related to the integration of

the businesses, should allow us to offset integration-related costs over time, this net benefit may not be achieved in the near term, or at all.

The merger may not be accretive, and may be dilutive, to our earnings per share, which may negatively affect the market price of shares of our common stock.

We currently project that the merger will result in a number of benefits, including enhanced competitive positioning and a platform from which to accelerate growth, and that it will be accretive to earnings per share in the second full year after the close of the transaction. This projection is based on preliminary estimates that may materially change. In addition, future events and conditions could decrease or delay the accretion that is currently projected or could result in dilution, including adverse changes in market conditions, additional transaction and integration-related costs and other factors such as the failure to realize some or all of the anticipated benefits of the merger. Any dilution of, decrease in or delay of any accretion to, our earnings per share could cause the price of shares of our common stock to decline or grow at a reduced rate.

The future results of the combined company may be adversely impacted if the combined company does not effectively manage its expanded operations following completion of the merger.

Following completion of the merger, the size of the combined company's business will be significantly larger than the current size of either our or Aetna's respective businesses. The combined company's ability to successfully manage this expanded business will depend, in part, upon management's ability to implement an effective integration of the two companies and its ability to manage a combined business with significantly larger size and scope with the associated increased costs and complexity. There can be no assurances that the management of the combined company will be successful or that the combined company will realize the expected operating efficiencies, cost savings and other benefits currently anticipated from the merger.

Additional information concerning these risks, uncertainties and assumptions can be found in the section entitled "Risk Factors" beginning on page 62 of our preliminary joint proxy statement/prospectus filed February 9, 2018 with the SEC on Form S-4/A.

Item 1B. Unresolved Staff Comments

There are no unresolved SEC Staff Comments.

Item 2. Properties

We lease most of our stores under long-term leases that vary as to rental amounts, expiration dates, renewal options and other rental provisions. For additional information on the amount of our rental obligations for our leases, we refer you to Note 7 "Leases" in our Annual Report to Stockholders for the year ended December 31, 2017, which section is incorporated by reference herein.

As of December 31, 2017, we owned approximately 4% of our 8,108 retail stores. Net selling space for our retail stores was approximately 79.5 million square feet as of December 31, 2017. Approximately 20% of our store base was opened or significantly remodeled within the last five years.

We lease 1,695 retail pharmacies and 79 clinics in Target stores located in 47 states and the District of Columbia.

We own nine distribution centers located in Alabama, California, Hawaii, New York, Rhode Island, South Carolina, Tennessee and Texas and lease 13 additional distribution facilities located in Arizona, Florida, Indiana, Michigan, Missouri, New Jersey, Pennsylvania, Texas, Virginia and Brazil. The 22 distribution centers total approximately 10.4 million square feet as of December 31, 2017.

As of December 31, 2017, we owned six and leased 139 LTC pharmacies in 44 states and owned one LTC repackaging facility in Kentucky.

As of December 31, 2017, we owned one mail service dispensing pharmacy located in Texas and leased three additional mail order dispensing pharmacies located in Hawaii, Illinois and Pennsylvania; we leased call centers located in California, Missouri, Pennsylvania, Tennessee and Texas; we leased 37 onsite pharmacy stores and 23 specialty pharmacy stores, and leased 18 specialty mail order pharmacies; we leased 83 branches for infusion and enteral services, including approximately 73 ambulatory infusion suites and three centers of excellence.

We own our corporate offices located in Woonsocket, Rhode Island, which totals approximately one million square feet. In addition, we lease corporate offices in Scottsdale, Arizona, Northbrook, Illinois, Cincinnati, Ohio, Monroeville, Pennsylvania, Irving, Texas, and Sao Paulo, Brazil.

In connection with certain business dispositions completed between 1991 and 1997, we continue to guarantee lease obligations for approximately 85 former stores. We are indemnified for these guarantee obligations by the respective purchasers. These guarantees generally remain in effect for the initial lease term and any extension thereof pursuant to a renewal option provided for in the lease prior to the time of the disposition. For additional information, we refer you to Note 12 “Commitments and Contingencies” in our Annual Report to Stockholders for the year ended December 31, 2017, which section is incorporated by reference herein.

Management believes that the Company’s owned and leased facilities are suitable and adequate to meet the Company’s anticipated needs. At the end of the existing lease terms, management believes the leases can be renewed or replaced by alternative space.

The following is a breakdown by state, District of Columbia, Puerto Rico and Brazil of our retail stores, pharmacies and clinics in Target stores, LTC hub and spoke pharmacies, onsite pharmacy stores, specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies and branches and centers of excellence for infusion and enteral services as of December 31, 2017:

	Retail Stores [1]	Pharmacies within Target [1]	LTC Hub & Spoke Pharmacies	Onsite Pharmacy Stores	Specialty Pharmacy Stores	Specialty Mail Order Pharmacies	Mail Order Dispensing Pharmacies	Infusion & Enteral Services Locations	Total
United States:									
Alabama	160	22	2	1	1	—	—	1	187
Alaska	3	3	—	—	—	—	—	—	6
Arizona	152	46	2	—	1	1	—	2	204
Arkansas	15	8	1	—	—	—	—	1	25
California	886	260	8	—	3	1	—	8	1,166
Colorado	3	39	3	—	1	—	—	1	47
Connecticut	154	20	1	1	—	—	—	1	177
Delaware	17	3	—	—	—	—	—	—	20
District of Columbia	58	1	—	—	1	—	—	—	60
Florida	754	121	5	1	1	2	—	7	891
Georgia	311	41	1	3	1	—	—	1	358
Hawaii	64	7	—	—	1	—	1	—	73
Idaho	—	2	1	—	—	—	—	1	4
Illinois	282	90	7	2	—	1	1	3	386
Indiana	309	30	4	—	—	—	—	3	346
Iowa	20	18	2	—	—	—	—	1	41
Kansas	39	14	2	—	—	1	—	2	58
Kentucky	70	9	9	—	—	1	—	—	89
Louisiana	119	14	3	—	—	—	—	1	137
Maine	22	5	1	—	—	—	—	1	29
Maryland	185	39	2	5	—	—	—	1	232
Massachusetts	376	40	5	2	2	1	—	1	427
Michigan	248	50	4	1	—	1	—	2	306
Minnesota	61	75	6	1	—	—	—	2	145
Mississippi	52	5	1	1	—	—	—	1	60
Missouri	97	33	5	—	—	—	—	1	136
Montana	14	2	1	—	—	—	—	—	17
Nebraska	19	11	1	—	—	—	—	1	32
Nevada	86	15	2	—	—	—	—	2	105
New Hampshire	40	9	1	—	—	—	—	—	50
New Jersey	291	45	3	4	—	1	—	1	345
New Mexico	19	6	1	—	—	—	—	1	27
New York	489	75	5	—	1	—	—	7	577
North Carolina	314	51	3	1	1	1	—	3	374
North Dakota	6	—	—	—	—	—	—	—	6
Ohio	329	59	7	—	—	—	—	4	399
Oklahoma	62	15	2	—	—	—	—	1	80
Oregon	—	18	2	—	1	1	—	1	23
Pennsylvania	410	66	6	2	1	1	1	2	489
Puerto Rico	25	—	—	—	—	1	—	—	26
Rhode Island	62	4	1	1	1	—	—	1	70
South Carolina	191	19	3	1	1	—	—	2	217
South Dakota	—	3	1	—	—	—	—	—	4
Tennessee	136	27	3	1	1	3	—	3	174
Texas	695	135	10	3	2	1	1	5	852
Utah	12	13	2	—	—	—	—	1	28
Vermont	10	—	—	—	—	—	—	—	10
Virginia	286	58	6	5	1	—	—	2	358
Washington	12	30	3	—	1	—	—	2	48
West Virginia	51	6	2	—	—	—	—	—	59
Wisconsin	50	33	5	1	—	—	—	1	90
Wyoming	—	—	—	—	—	—	—	1	1
Total United States	8,066	1,695	145	37	23	18	4	83	10,071
Brazil	42	—	—	—	—	—	—	—	42
Total	8,108	1,695	145	37	23	18	4	83	10,113

(1) The Retail Stores above include 1,050 in-store MinuteClinic locations and the Target stores with CVS pharmacies also include 79 MinuteClinic locations.

Item 3. Legal Proceedings

I. Legal Proceedings

We refer you to the Note 12 “Commitments and Contingencies” contained in the “Notes to the Consolidated Financial Statements” of our Annual Report to Stockholders for the year ended December 31, 2017, which section is incorporated by reference herein.

II. Environmental Matters

Item 103 of SEC Regulation S-K requires disclosure of certain environmental legal proceedings if management reasonably believes that the proceedings involve potential monetary sanctions of $100,000 or more. The Company is in the process of negotiating with the New York State Department of Environmental Conservation to resolve claims of alleged historical noncompliance with hazardous waste regulations in connection with long-term care pharmacies in the State of New York. These proceedings are not material to the Company's business or financial position.

Item 4. Mine Safety Disclosures

Not applicable.

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Executive Officers of the Registrant

Executive Officers of the Registrant

The following sets forth the name, age and biographical information for each of our executive officers as of February 14, 2018. In each case the officer's term of office extends to the date of the board of directors meeting following the next annual meeting of stockholders of the Company. Previous positions and responsibilities held by each of the executive officers over the past five years are indicated below:

Lisa G. Bisaccia, age 61, Executive Vice President of CVS Health Corporation since March 2016 and Chief Human Resources Officer of CVS Health Corporation since January 2010; Senior Vice President of CVS Health Corporation from January 2010 through February 2016; Vice President, Human Resources of CVS Pharmacy, Inc. from September 2004 through December 2009. Ms. Bisaccia is also a member of the Board of Directors of Aramark, a leading global provider of food, facilities and uniform services.

Eva C. Boratto, age 51, Executive Vice President - Controller and Chief Accounting Officer of CVS Health Corporation since March 2017; Senior Vice President - Controller and Chief Accounting Officer of CVS Health Corporation from July 2013 through February 2017; Senior Vice President of PBM Finance from July 2010 through June 2013; Vice President, U.S. Market Finance Leader of Merck & Co., Inc. from June 2009 through June 2010.

Troyen A. Brennan, M.D., age 63, Executive Vice President and Chief Medical Officer of CVS Health Corporation since November 2008; Executive Vice President and Chief Medical Officer of Aetna, Inc. from February 2006 through November 2008.

David M. Denton, age 52, Executive Vice President and Chief Financial Officer of CVS Health Corporation since January 2010; Senior Vice President and Controller and Chief Accounting Officer of CVS Health Corporation from March 2008 until December 2009; Senior Vice President, Financial Administration of CVS Health Corporation and CVS Pharmacy, Inc. from April 2007 to March 2008. Mr. Denton is also a member of the Board of Directors of Tapestry, Inc. (formerly known as Coach, Inc.), a leading retailer of premium bags and luxury accessories.

Larry J. Merlo, age 62, President and Chief Executive Officer of CVS Health Corporation since March 2011; President and Chief Operating Officer of CVS Health Corporation from May 2010 through March 2011; President of CVS Pharmacy from January 2007 through August 2011; Executive Vice President of CVS Health Corporation from January 2007 through May 2010; also a director of CVS Health Corporation since May 2010.

Thomas M. Moriarty, age 54, Executive Vice President and General Counsel of CVS Health Corporation since October 2012 and Chief Policy and External Affairs Officer since March 2017; Chief Strategy Officer from March 2014 through February 2017; General Counsel of Celgene Corporation, a global biopharmaceutical company, from May 2012 through September 2012; General Counsel and Corporate Secretary of Medco Health Solutions, Inc. ("Medco"), a pharmacy benefit management company, from March 2008 through April 2012; also President of Global Pharmaceutical Strategies of Medco from March 2011 through April 2012.

Jonathan C. Roberts, age 62, Executive Vice President and Chief Operating Officer of CVS Health Corporation since March 2017; Executive Vice President of CVS Health Corporation and President of CVS Caremark from September 2012 through February 2017; Executive Vice President of CVS Health Corporation and Chief Operating Officer of CVS Caremark from October 2010 through August 2011; Executive Vice President, Rx Purchasing, Pricing and Network Relations of CVS Health Corporation from January 2009 through October 2010.

PART II

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

Our common stock is listed on the New York Stock Exchange under the symbol "CVS." The table below sets forth the high and low closing prices of our common stock on the New York Stock Exchange Composite Tape and the quarterly cash dividends declared per share of common stock during the periods indicated.

	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Year
2017 High	$83.92	$82.79	$83.31	$80.91	$ 83.92
Low	$74.80	$75.95	$75.35	$66.80	$ 66.80
Cash dividends per common share	$0.50	$ 0.50	$0.50	$ 0.50	$ 2.00
2016 High	$104.05	$106.10	$98.06	$88.80	$106.10
Low	$89.65	$93.21	$88.99	$73.53	$ 73.53
Cash dividends per common share	$0.425	$0.425	$0.425	$0.425	$ 1.70

CVS Health has paid cash dividends every quarter since becoming a public company. Future dividend payments will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Company's Board of Directors. As of February 9, 2018, there were 21,453 registered shareholders according to the records maintained by our transfer agent.

The following share repurchase programs were authorized by the Company's Board of Directors:

In billions Authorization Date	Authorized	Remaining as of December 31, 2017
November 2, 2016 ("2016 Repurchase Program")	$ 15.0	$ 13.9
December 15, 2014 ("2014 Repurchase Program")	10.0	—
December 17, 2013 ("2013 Repurchase Program")	6.0	—

The share Repurchase Programs, each of which was effective immediately, permit the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase ("ASR") transactions, and/or other derivative transactions. The 2016 Repurchase Program can be modified or terminated by the Board of Directors at any time.

Pursuant to the authorization under the 2014 Repurchase Program, in August 2016, the Company entered into two fixed dollar ASRs with Barclays Bank PLC ("Barclays") for a total of $3.6 billion. Upon payment of the $3.6 billion purchase price in January 2017, the Company received a number of shares of its common stock equal to 80% of the $3.6 billion notional amount of the ASRs or approximately 36.1 million shares, which were placed into treasury stock in January 2017. The ASRs were accounted for as an initial treasury stock transaction for $2.9 billion and a forward contract for $0.7 billion. In April 2017, the Company received 9.9 million shares of common stock, representing the remaining 20% of the $3.6 billion notional amount of the ASRs, thereby concluding the ASRs. The remaining 9.9 million shares of common stock delivered to the Company by Barclays were placed into treasury stock and the forward contract was reclassified from capital surplus to treasury stock in April 2017.

In the ASR transactions described above, the initial repurchase of the shares and delivery of the remainder of the shares to conclude the ASR, resulted in an immediate reduction of the outstanding shares used to calculate the weighted average common shares outstanding for basic and diluted earnings per share.

During the year ended December 31, 2017, the Company repurchased an aggregate of 55.4 million shares of common stock for approximately $4.4 billion under the 2014 and 2016 Repurchase Programs. As of December 31, 2017, there remained an aggregate of approximately $13.9 billion available for future repurchases under the 2016 Repurchase Program and the 2014 Repurchase Program was complete. During the fourth quarter of 2017, the Company suspended share repurchase activity in connection with the Aetna Acquisition.

Fiscal Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs
October 1, 2017 through October 31, 2017	—	$ —	—	$13,869,392,446
November 1, 2017 through November 30, 2017	—	$ —	—	$13,869,392,446
December 1, 2017 through December 31, 2017	—	$ —	—	$13,869,392,446
	—		—	

Item 6. Selected Financial Data

The selected consolidated financial data of CVS Health Corporation as of and for the periods indicated in the five-year period ended December 31, 2017, have been derived from the consolidated financial statements of CVS Health Corporation. The selected consolidated financial data should be read in conjunction with the consolidated financial statements and the audit reports of Ernst & Young LLP, which are incorporated elsewhere herein.

In millions, except per share amounts	2017	2016	2015	2014	2013
Statement of operations data:					
Net revenues	$184,765	$177,526	$153,290	$139,367	$126,761
Gross profit	28,545	28,857	26,528	25,367	23,783
Operating expenses [1]	19,028	18,491	17,053	16,545	15,713
Operating profit	9,517	10,366	9,475	8,822	8,070
Interest expense, net	1,041	1,058	838	600	509
Loss on early extinguishment of debt	—	643	—	521	—
Other expense [1]	208	28	21	23	33
Income tax provision	1,637	3,317	3,386	3,033	2,928
Income from continuing operations	6,631	5,320	5,230	4,645	4,600
Income (loss) from discontinued operations, net of tax	(8)	(1)	9	(1)	(8)
Net income	6,623	5,319	5,239	4,644	4,592
Net income attributable to noncontrolling interest	(1)	(2)	(2)	—	—
Net income attributable to CVS Health	$ 6,622	$ 5,317	$ 5,237	$ 4,644	$ 4,592
Per common share data:					
Basic earnings per common share:					
Income from continuing operations attributable to CVS Health	$ 6.48	$ 4.93	$ 4.65	$ 3.98	$ 3.78
Income (loss) from discontinued operations attributable to CVS Health	$ (0.01)	$ —	$ 0.01	$ —	$ (0.01)
Net income attributable to CVS Health	$ 6.47	$ 4.93	$ 4.66	$ 3.98	$ 3.77
Diluted earnings per common share:					
Income from continuing operations attributable to CVS Health	$ 6.45	$ 4.91	$ 4.62	$ 3.96	$ 3.75
Income (loss) from discontinued operations attributable to CVS Health	$ (0.01)	$ —	$ 0.01	$ —	$ (0.01)
	$ 6.44	$ 4.90	$ 4.63	$ 3.96	$ 3.74

Net income attributable to CVS Health					
Cash dividends per common share	$ 2.00	$ 1.70	$ 1.40	$ 1.10	$ 0.90
Balance sheet and other data:					
Total assets	$ 95,131	$ 94,462	$ 92,437	$ 73,202	$ 70,550
Long-term debt	$ 22,181	$ 25,615	$ 26,267	$ 11,630	$ 12,767
Total shareholders' equity	$ 37,695	$ 36,834	$ 37,203	$ 37,963	$ 37,938
Number of stores (at end of year)	9,846	9,750	9,681	7,866	7,702

(1) As of January 1, 2017, the Company adopted Accounting Standards Update ("ASU") 2017-07, *Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*, which resulted in a retrospective reclassification of $28 million, $21 million, $23 million and $33 million of net benefit costs from operating expenses to other expense in the years ended December 31, 2016, 2015, 2014, and 2013, respectively.

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

We refer you to "Management's Discussion and Analysis of Financial Condition and Results of Operations," which includes our "Cautionary Statement Concerning Forward-Looking Statements" at the end of such section of our Annual Report to Stockholders for the year ended December 31, 2017, which section is incorporated by reference herein.

Item 7A. Quantitative and Qualitative Disclosures about Market Risk

As of December 31, 2017, the Company had outstanding interest rate derivative instruments and believes that as of December 31, 2017, its exposure to interest rate risk (inherent in the Company's debt portfolio) is not material. We refer you to Note 1 "Significant Accounting Policies" contained in the "Notes to the Consolidated Financial Statements" of our Annual Report to Stockholders for the year ended December 31, 2017, which section is incorporated by reference herein.

As of December 31, 2017, the Company did not have any foreign currency exchange rate or commodity derivative instruments in place and believes that as of December 31, 2017, its exposure to foreign currency exchange rate risk and commodity price risk is not material

Item 8. Financial Statements and Supplementary Data

We refer you to the "Consolidated Statements of Income," "Consolidated Statements of Comprehensive Income," "Consolidated Balance Sheets," "Consolidated Statements of Shareholders' Equity," "Consolidated Statements of Cash Flows," "Notes to Consolidated Financial Statements," and "Report of Independent Registered Public Accounting Firm" of our Annual Report to Stockholders for the year ended December 31, 2017, which sections are incorporated by reference herein.

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

None.

Item 9A. Controls and Procedures

Evaluation of disclosure controls and procedures: The Company's Chief Executive Officer and Chief Financial Officer, after evaluating the effectiveness of the design and operation of the Company's disclosure controls and procedures (as defined in Rules 13a-15 (f) and 15d-15(f) under the Securities Exchange Act of 1934) as of December 31, 2017, have concluded that as of such date the Company's disclosure controls and procedures were adequate and effective at a reasonable assurance level and designed to ensure that material information relating to the Company and its subsidiaries would be made known to such officers on a timely basis.

Internal control over financial reporting: We refer you to "Management's Report on Internal Control Over Financial Reporting" and "Report of Independent Registered Public Accounting Firm" of our Annual Report to Stockholders for the fiscal year ended December 31, 2017, which are incorporated by reference herein, for management's report on the Company's internal control over financial reporting and the Independent Registered Public Accounting Firm's report with respect to the effectiveness of internal control over financial reporting.

Changes in internal control over financial reporting: There have been no changes in our internal controls over financial reporting identified in connection with the evaluation required by paragraph (d) of Rule 13a-15 or Rule 15d-15 that occurred during the fourth quarter ended December 31, 2017 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information

No events have occurred during the fourth quarter that would require disclosure under this item.

PART III

Item 10. Directors, Executive Officers and Corporate Governance

We refer you to our Proxy Statement for the 2018 Annual Meeting of Stockholders under the captions “Committees of the Board,” “Code of Conduct,” “Director Nominations,” “Audit Committee Report,” “Biographies of our Board Nominees,” and “Section 16(a) Beneficial Ownership Reporting Compliance,” which sections are incorporated by reference herein. Biographical information on our executive officers is contained in Part I of this Annual Report on Form 10-K.

Item 11. Executive Compensation

We refer you to our Proxy Statement for the 2018 Annual Meeting of Stockholders under the captions “Executive Compensation and Related Matters,” including “Compensation Discussion & Analysis” and “Management Planning and Development Committee Report,” which sections are incorporated by reference herein.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

We refer you to our Proxy Statement for the 2018 Annual Meeting of Stockholders under the captions “Share Ownership of Directors and Certain Executive Officers,” and “Share Ownership of Principal Stockholders” which sections are incorporated by reference herein, for information concerning security ownership of certain beneficial owners and management and related stockholder matters.

The following table summarizes information about the Company’s common stock that may be issued upon the exercise of options, warrants and rights under all of our equity compensation plans as of December 31, 2017.

	Number of securities to be issued upon exercise of outstanding options, warrants and rights[1]	Weighted average exercise price of outstanding options, warrants and rights	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in first column) [1]
Equity compensation plans approved by stockholders	32,219	$ 75.32	20,530
Equity compensation plans not approved by stockholders	—	—	—
Total	32,219	$ 75.32	20,530

(1) Shares in thousands.

Item 13. Certain Relationships and Related Transactions and Director Independence

We refer you to our Proxy Statement for the 2018 Annual Meeting of Stockholders under the caption “Independence Determinations for Directors” and “Certain Transactions with Directors and Officers,” which sections are incorporated by reference herein.

Item 14. Principal Accountant Fees and Services

We refer you to our Proxy Statement for the 2018 Annual Meeting of Stockholders under the caption “Item 2: Ratification of Appointment of Independent Registered Public Accounting Firm,” which section is incorporated by reference herein.

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PART IV

Item 15. Exhibits and Financial Statement Schedules

A. Documents filed as part of this report:

1. Financial Statements:

The following financial statements are incorporated by reference from our Annual Report to Stockholders for the fiscal year ended December 31, 2017, as provided in Item 8 hereof:

Consolidated Statements of Income for the Years Ended December 31, 2017, 2016 and 2015
Consolidated Statements of Comprehensive Income for the Years Ended December 31, 2017, 2016 and 2015
Consolidated Balance Sheets as of December 31, 2017 and 2016
Consolidated Statements of Cash Flows for the Years Ended December 31, 2017, 2016 and 2015
Consolidated Statements of Shareholders' Equity for the Years Ended December 31, 2017, 2016 and 2015
Notes to Consolidated Financial Statements
Report of Independent Registered Public Accounting Firm

2. Financial Statement Schedules

All financial statement schedules are omitted because they are not applicable, not required under the instructions, or the information is included in the consolidated financial statements or related notes.

B. Exhibits

Exhibits marked with an asterisk (*) are hereby incorporated by reference to exhibits or appendices previously filed by the Registrant as indicated in brackets following the description of the exhibit.

Exhibit	Description
2.1*	Agreement and Plan of Merger dated as of November 1, 2006 among, the Registrant, Caremark Rx, Inc. and Twain MergerSub Corp. (incorporated by reference to Exhibit 2.1 to the Registrant's Registration Statement No. 333-139470 on Form S-4 filed December 19, 2006).
2.2*	Amendment No. 1 dated as of January 16, 2007 to the Agreement and Plan of Merger dated as of November 1, 2006 among the Registrant, Caremark Rx, Inc. and Twain Merger Sub Corp. (incorporated by reference to Exhibit 2.2 to the Registrant's Registration Statement No. 333-139470 on Form S-4/A filed January 16, 2007).
2.3*	Waiver Agreement dated as of January 16, 2007 between the Registrant and Caremark Rx, Inc. with respect to the Agreement and Plan Merger dated as of November 1, 2006 by and between Registrant and Caremark Rx, Inc (incorporated by reference to Exhibit 2.3 to the Registrant's Registration Statement No. 333-139470 on Form S-4/A filed January 16, 2007).

2.4*	Amendment to Waiver Agreement, dated as of February 12, 2007, between Registrant and Caremark Rx, Inc. (incorporated by reference to Exhibit 99.2 to the Registrant's Current Report on Form 8-K dated February 13, 2007; Commission File No. 001-01011).
2.5*	Amendment to Waiver Agreement, dated as of March 8, 2007, between Registrant and Caremark Rx, Inc. (incorporated by reference to Exhibit 99.2 to the Registrant's Current Report on Form 8-K dated March 8, 2007; Commission File No. 001-01011).
2.6*	Agreement and Plan of Merger dated as of August 12, 2008, among the Registrant, Longs Drug Stores Corporation and Blue MergerSub Corp. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K dated August 13, 2008; Commission File No. 001-01011).

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2.7*	Agreement and Plan of Merger, dated as of May 20, 2015, among CVS Pharmacy, Inc., Tree Merger Sub, Inc. and Omnicare, Inc. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K dated May 21, 2015; Commission File No. 001-01011).
2.8*	Agreement and Plan of Merger, dated as of December 3, 2017, among CVS Health Corporation, Hudson Merger Sub Corp. and Aetna Inc. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K dated December 5, 2017; Commission File No. 001-01011).
2.9*	Bridge Facility Commitment Letter dated December 3, 2017, by and among the Registrant, Barclays Bank PLC, Goldman Sachs Bank USA, Goldman Sachs Lending Partners LLC, Bank of America, N.A., and Merrill Lynch, Pierce Fenner & Smith Incorporated (incorporated by reference to Exhibit 2.2 to the Registrant's Current Report on Form 8-K dated December 5, 2017; Commission File No. 001-01011).
2.10*	Joinder to Bridge Facility Commitment Letter dated as of December 15, 2017, by and among the Registrant, Barclays Bank PLC, Goldman Sachs Bank USA, Goldman Sachs Lending Partners LLC, Bank of America, N.A., Merrill Lynch, Pierce, Fenner & Smith Incorporated, and each of the Additional Commitment Parties party thereto (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K dated December 19, 2017; Commission File No. 001-01011).
3.1*	Amended and Restated Certificate of Incorporation of the Registrant (incorporated by reference to Exhibit 3.1 of Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 1996; Commission File No. 001-01011).
3.1A*	Certificate of Amendment to the Amended and Restated Certificate of Incorporation, effective May 13, 1998 (incorporated by reference to Exhibit 4.1A to Registrant's Registration Statement No. 333-52055 on Form S-3/A dated May 18, 1998).
3.1B*	Certificate of Amendment to the Amended and Restated Certificate of Incorporation (incorporated by reference to Exhibit 3.1 to Registrant's Current Report on Form 8-K dated March 22, 2007; Commission File No. 001-01011).
3.1C*	Certificate of Merger dated May 9, 2007 (incorporated by reference to Exhibit 3.1C to Registrant's Quarterly Report on Form 10-Q dated November 1, 2007; Commission File No. 001-01011).
3.1D*	Certificate of Amendment to the Amended and Restated Certificate of Incorporation (incorporated by reference to Exhibit 3.1 to Registrant's Current Report on Form 8-K dated May 13, 2010; Commission File No. 001-01011).
3.1E*	Certificate of Amendment to the Amended and Restated Certificate of Incorporation (incorporated by reference to Exhibit 3.1 to the Registrant's Current Report On Form 8-K dated May 10, 2012; Commission File No. 001-01011).
3.1F*	Certificate of Amendment to the Amended and Restated Certificate of Incorporation (incorporated by reference to Exhibit 3.1 to the Registrant's Current Report On Form 8-K dated May 13, 2013; Commission File No. 001-01011).
3.1G*	Certificate of Amendment to the Amended and Restated Certificate of Incorporation (incorporated by reference to Exhibit 3.1 to the Registrant's Current Report on Form 8-K dated September 3, 2014 (Commission File No. 001-01011)).

3.2*	By-laws of the Registrant, as amended and restated (incorporated by reference to Exhibit 3.2 to the Registrant's Current Report on Form 8-K dated January 26, 2016; Commission File No. 001-01011).
4	Pursuant to Regulation S-K, Item 601(b)(4)(iii)(A), no instrument which defines the rights of holders of long-term debt of the Registrant and its subsidiaries is filed with this report. The Registrant hereby agrees to furnish a copy of any such instrument to the Securities and Exchange Commission upon request.

4.1*	Specimen common stock certificate (incorporated by reference to Exhibit 4.1 to the Registration Statement of the Registrant on Form 8-B dated November 4, 1996; Commission File No. 001-01011).
10.1*	Stock Purchase Agreement dated as of October 14, 1995 between The TJX Companies, Inc. and Melville Corporation, as amended November 17, 1995 (incorporated by reference to Exhibits 2.1 and 2.2 to Melville's Current Report on Form 8-K dated December 4, 1995; Commission File No. 001-01011).
10.2*	Stock Purchase Agreement dated as of March 25, 1996 between Melville Corporation and Consolidated Stores Corporation, as amended May 3, 1996 (incorporated by reference to Exhibits 2.1 and 2.2 to Melville's Current Report on Form 8-K dated May 5, 1996; Commission File No. 001-01011).
10.3*	Distribution Agreement dated as of September 24, 1996 among Melville Corporation, Footstar, Inc. and Footstar Center, Inc. (incorporated by reference to Exhibit 99.1 to Melville's Current Report on Form 8-K dated October 28, 1996; Commission File No. 001-01011).
10.4*	Tax Disaffiliation Agreement dated as of September 24, 1996 among Melville Corporation, Footstar, Inc. and certain subsidiaries named therein (incorporated by reference to Exhibit 99.2 to Melville's Current Report on Form 8-K dated October 28, 1996; Commission File No. 001-01011).
10.5*	Stockholder Agreement dated as of December 2, 1996 between the Registrant, Nashua Hollis CVS, Inc. and Linens 'n Things, Inc. (incorporated by reference to Exhibit 10(i)(6) to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 1997; Commission File No. 001-01011).
10.6*	Tax Disaffiliation Agreement dated as of December 2, 1996 between the Registrant and Linens 'n Things, Inc. and certain of their respective affiliates (incorporated by reference to Exhibit 10(i)(7) to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 1997; Commission File No. 001-01011).
10.7*	Second Amended and Restated Credit Agreement, dated as of July 24, 2014, by and among the Registrant, the lenders party thereto, Barclays Bank PLC and JPMorgan Chase Bank, N.A., as Co-Syndication Agents, Bank of America, N.A. and Wells Fargo Bank, N.A., as Co-Documentation Agents, and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014 (Commission File No. 001-01011).
10.8*	Amendment No. 1 to Second Amended and Restated Credit Agreement, dated as of December 15, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as administrative agent (incorporated by reference to Exhibit 10.4 to the Registrant's Current Report on Form 8-K dated December 19, 2017; Commission File No. 001-01011).
10.9*	Five Year Credit Agreement dated as of July 1, 2015, by and among the Registrant, the lenders party thereto, Barclays Bank PLC and JPMorgan Chase Bank, N.A., as Co-Syndication Agents, Bank of America, N.A. and Wells Fargo Bank, N.A., as Co-Documentation Agents, and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2015 (Commission File No. 001-01011).
10.10*	Amendment No. 1, dated as of December 15, 2017, to Five Year Credit Agreement dated as of July 1, 2015, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as administrative agent

	(incorporated by reference to Exhibit 10.5 to the Registrant's Current Report on Form 8-K dated December 19, 2017; Commission File No. 001-01011).
10.11*	364-Day Credit Agreement, dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as administrative agent (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011).

10.12*	Amendment No. 1, dated as of December 15, 2017, to 364-Day Credit Agreement dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as administrative agent (incorporated by reference to Exhibit 10.2 to the Registrant's Current Report on Form 8-K dated December 19, 2017; Commission File No. 001-01011).
10.13*	Five Year Credit Agreement, dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as administrative agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011).
10.14*	Amendment No. 1 dated as of December 15, 2017, to Five Year Credit Agreement dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as administrative agent (incorporated by reference to Exhibit 10.3 to the Registrant's Current Report on Form 8-K dated December 19, 2017; Commission File No. 001-01011).
10.15*	Term Loan Agreement dated as of December 15, 2017, by and among the Registrant, the lenders party thereto and Barclays Bank PLC, as administrative agent (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K dated December 19, 2017; Commission File No. 001-01011).
10.16*	The Registrant's Supplemental Retirement Plan for Select Senior Management I as amended and restated in December 2008 (incorporated by reference to Exhibit 10.6 to the Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009; Commission File No. 001-01011).
10.17*	The Registrant's 1996 Directors Stock Plan, as amended and restated November 5, 2002 (incorporated by reference to Exhibit 10.18 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 28, 2002; Commission File No. 001-01011).
10.18*	The Registrant's 1997 Incentive Compensation Plan as amended through December 2008 (incorporated by reference to Exhibit 10.8 to the Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009; Commission File No. 001-01011).
10.19*	Caremark Rx, Inc. 2004 Incentive Stock Plan (incorporated by reference to Exhibit 99.2 of the Registrant's Registration Statement No. 333-141481 on Form S-8 filed March 22, 2007; Commission File No. 011-01011).
10.20*	The Registrant's Deferred Stock Compensation Plan, as amended (incorporated by reference to Exhibit 10.17 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011).
10.21*	The Registrant's Deferred Compensation Plan, as amended (incorporated by reference to Exhibit 10.19 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.22*	The Registrant's 2010 Incentive Compensation Plan, as amended through January 15, 2013 (incorporated by reference to Exhibit A to the Registrant's Definitive Proxy Statement on Form 14A filed March 27, 2015; Commission File No. 001-01011).
10.23*	The Registrant's 2017 Incentive Compensation Plan (incorporated by reference to Exhibit A to the Registrant's Definitive Proxy Statement on Form 14A filed March 31, 2017; Commission File No. 001-01011).
10.24*	

	The Registrant's 2007 Employee Stock Purchase Plan, as amended (incorporated by reference to Exhibit 10.20 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011).

10.25*	The Registrant's Management Incentive Plan (incorporated by reference to Exhibit 10.3 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011).
10.26*	The Registrant's Executive Incentive Plan (incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011).
10.27*	The Registrant's Long-Term Incentive Plan (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011).
10.28*	The Registrant's Partnership Equity Program, as amended (incorporated by reference to Exhibit 10.25 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.29*	The Registrant's Severance Plan for Non-Store Employees amended as of January 2016 (incorporated by reference to Exhibit 10.25 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.30*	The Registrant's Performance-Based Restricted Stock Unit Plan, as amended (incorporated by reference to Exhibit 10.27 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.31*	Form of Enterprise Non-Competition, Non-Disclosure and Developments Agreement between the Registrant and certain of the Registrant's executive officers (incorporated by reference to Exhibit 10.25 of the Registrant's Annual Report on Form 10-K for the year ended December 31, 2013; Commission File No. 001-01011).
10.32*	Universal 409A Definition Document, as amended (incorporated by reference to Exhibit 10.28 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011).
10.33*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.29 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.34*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.30 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.35*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.36*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax) (incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.37*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Post-Tax) (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).

10.38*	Amended and Restated Employment Agreement dated as of December 22, 2008 between the Registrant and the Registrant's President and Chief Executive Officer (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2008; Commission File No. 001-01011).
10.39*	Amendment dated December 21, 2012 to the Amended and Restated Employment Agreement dated as of December 22, 2008 between the Registrant and the Registrant's President and Chief Executive Officer (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.40*	Form of Non-Qualified Stock Option Agreement between the Registrant and the Registrant's President and Chief Executive Officer (incorporated by reference to Exhibit 10.37 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.41*	Form of Restricted Stock Unit Agreement between the Registrant and the Registrant's President and Chief Executive Officer (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.42*	Amendment dated January 22, 2015 to Nonqualified Stock Option Agreements between the Registrant and the Registrant's President and Chief Executive Officer (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K dated January 23, 2015; Commission File No. 001-01011).
10.43*	Change in Control Agreement dated December 22, 2008 between the Registrant and the Registrant's Executive Vice President and Chief Financial Officer (incorporated by reference to Exhibit 10.39 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2010; Commission File No. 001-01011).
10.44*	Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and the Registrant's Executive Vice President and Chief Financial Officer (incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.45*	Change in Control Agreement dated December 22, 2008 between the Registrant and the Registrant's Executive Vice President and Chief Operating Officer (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.46*	Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and the Registrant's Executive Vice President and Chief Operating Officer (incorporated by reference to Exhibit 10.34 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.47*	Restricted Stock Unit Agreement dated April 1, 2017 between the Registrant and the Registrant's Executive Vice President and Chief Operating Officer (incorporated by reference to Exhibit 10.44 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.48*	Restrictive Covenant Agreement dated May 20, 2017 between the Registrant and the Registrant's Executive Vice President and Chief Operating Officer (incorporated by reference to Exhibit 10.45 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).

10.49*	Change in Control Agreement dated December 22, 2008 between the Registrant and the Registrant's Executive Vice President and President of CVS Pharmacy (incorporated by reference to Exhibit 10.43 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).

10.50*	Amendment dated as of December 31, 2012 to the Change in Control Agreement between the Registrant and the Registrant's Executive Vice President and President of CVS Pharmacy (incorporated by reference to Exhibit 10.44 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.51*	Change in Control Agreement dated October 1, 2012 between the Registrant and the Registrant's Executive Vice President, Chief Policy and External Affairs Officer and General Counsel (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2015; Commission File No. 001-01011).
10.52*	Restrictive Covenant Agreement dated June 1, 2014 between the Registrant and the Registrant's Executive Vice President, Chief Policy and External Affairs Officer and General Counsel (incorporated by reference to Exhibit 10.2 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2015; Commission File No. 001-01011).
12	Computation of Ratios of Earnings to Fixed Charges.
13	Portions of the 2018 Annual Report to Stockholders of CVS Health Corporation, which are specifically designated in this Form 10-K as being incorporated by reference.
21	Subsidiaries of the Registrant.
23	Consent of Ernst & Young LLP.
31.1	Certification by the Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification by the Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1	Certification by the Chief Executive Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification by the Chief Financial Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101	The following materials from the CVS Health Corporation Annual Report on Form 10-K for the year ended December 31, 2017 formatted in Extensible Business Reporting Language (XBRL): (i) the Consolidated Statements of Income, (ii) the Consolidated Balance Sheets, (iii) the Consolidated Statements of Cash Flows and (iv) related notes.

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SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this Annual Report on Form 10-K to be signed on its behalf by the undersigned, thereunto duly authorized.

CVS HEALTH CORPORATION

Date: February 14, 2018

By: /s/ DAVID M. DENTON
David M. Denton
Executive Vice President and Chief Financial Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title(s)	Date
/s/ RICHARD M. BRACKEN **Richard M. Bracken**	Director	February 14, 2018
/s/ C. DAVID BROWN II **C. David Brown II**	Director	February 14, 2018
/s/ EVA C. BORATTO **Eva C. Boratto**	Executive Vice President - Controller and Chief Accounting Officer (Principal Accounting Officer)	February 14, 2018
/s/ ALECIA A. DECOUDREAUX **Alecia A. DeCoudreaux**	Director	February 14, 2018
/s/ DAVID M. DENTON **David M. Denton**	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 14, 2018
/s/ NANCY-ANN M. DEPARLE **Nancy-Ann M. DeParle**	Director	February 14, 2018
/s/ DAVID W. DORMAN **David W. Dorman**	Chairman of the Board and Director	February 14, 2018
/s/ ANNE M. FINUCANE **Anne M. Finucane**	Director	February 14, 2018
/s/ LARRY J. MERLO **Larry J. Merlo**	President and Chief Executive Officer (Principal Executive Officer) and Director	February 14, 2018
/s/ JEAN-PIERRE MILLON **Jean-Pierre Millon**	Director	February 14, 2018
/s/ MARY L. SCHAPIRO **Mary L. Schapiro**	Director	February 14, 2018
/s/ RICHARD J. SWIFT **Richard J. Swift**	Director	February 14, 2018
/s/ WILLIAM C. WELDON **William C. Weldon**	Director	February 14, 2018
/s/ TONY L. WHITE	Director	February 14, 2018