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Jefferson Parish Government

Your choices matter.

Advance your retiree benefits program with a partner you can rely on

Highlights of our proposed strategy for Jefferson Parish Government for 2023 and beyond

aetna®

Making the right choice for your retirees

Imagine the possibilities with an MAPD partner who can help you do more with your resources to lower your costs and make a bigger impact on health and wellness! **That's where we come in.**

HOW WE'RE DIFFERENT	WHY IT MATTERS
We have an unrivaled hyperlocal footprint. As part of CVS Health®, our unparalleled suite of assets enables us to deliver greater, more accessible support to your retirees.	**You'll see better health in your retirees,** through more health resources for your retirees and more health engagement touchpoints for meaningful retiree interactions.
We are the most trustworthy and competent partner you'll find. We not only bring extensive experience with public sector plan sponsors, we also work with integrity and accountability.	**You can trust us to do what we say we'll do,** do the right thing for the right reason and take care of you and your retirees. Our priority is to make sure things are done right and issues are addressed quickly.
We are the best at helping plan sponsors achieve a more sustainable program. By tapping into our assets and experience, we deliver a better cost framework to ease your cost burden.	**You'll achieve a more financially sustainable and cost-efficient benefits program.** We'll proactively work with you ensure your retirees receive the best care and you achieve overall cost savings.

Through our proposal*, we're pleased to demonstrate our local presence, national scale and proven track record to deliver a better benefits solution for you and your retirees. **Let us show you how.**

National presence. Hyperlocal focus.

Our approach is different from anything else you'll find in the market:

Through our hyperlocal footprint, we offer **access to more providers and resources where your retirees live than anyone else**. As a result, you'll see **better health in your retirees**, even if your retirees live outside of Louisiana.

We have **more engagement touch points with retirees**, for example, ensuring retirees get their flu shots, or, for those members who choose to use one of our CVS pharmacies, they'll have the opportunity to engage with a pharmacist to improve health. More touch points help us close gaps in care, which not only **improves retiree health, but makes your program more affordable** as well.

We'll deliver **more accessible care through an extensive group of local practitioners** with our Healthy Home Visit program, our CVS MinuteClinic® and HealthHUB™ locations and our local wellness education and screening events throughout Ohio. Through these resources, you'll benefit from **substantially less noise and healthier retirees** when your population experiences more options for care closer to home.

1 CVS Health enterprise data analysis, as of February 2022.

We surround your retirees with support and options to achieve their best health

As a CVS Health® company, Aetna reaches members in unrivaled ways. But ***how*** we serve and engage is distinctly different. For example, some of our competitors focus outreach only on members likely to contribute to their CMS revenue goals.

We know that including more members in our outreach yields better overall results. That's why we surround your retirees with more wellness programs, services and support. The resulting improvements in health and reductions in medical cost from our unique model are **proof our approach is the right one**.

Teladoc, MDLive and Informed Healthline for quality health care 24/7/365 allows retirees to resolve many common, routine medical and behavioral health issues via video chat or phone.

SilverSneakers® fitness benefit helps members connect through social activities, including exercise and fitness classes at 17,000+ sports facilities nationwide.

Resources For Living℠ program advocates connect retirees to the local resources such as support or transportation groups.

Healthy Aging Support Program offers eight virtual, interactive sessions that engage members with chronic conditions at risk for complications to improve their health and well-being with valuable health information and achievable goals.

Comprehensive behavioral health support and treatment to address conditions such as substance abuse, bereavement, depression and anxiety.

Reimbursements offer your retirees peace of mind $300 every 12 months for vision eyewear, and $1,000 every 12 months for hearing aids.

Enhanced post-discharge planning nurses identify and address member issues and needs before discharge to increase the likelihood members will safely and comfortably transition home. Support includes **14 convenient and nutritious home-delivered meals**, which help ease members' post-hospitalization recovery.

Safe, comfortable non-emergency transportation ensures members with transportation issues can get to and from medical appointments; 24 one-way trips are covered per member at up to 60 miles each.

Building trust through our deep experience with groups like yours

We understand that your job of securing benefits for your retiree population is an awesome responsibility. Not only do **your retirees rely on you to find a carrier they can trust to handle their health issues**, but their families, friends and caregivers are all relying on you as well.

Trust is a crucial element of how we work with our clients and retirees, and it's just as crucial to the success of your program. **Our retiree members are like family to us**, so you can trust us to take care of them in a responsive, compassionate and professional manner.

We have hundreds of clients of all sizes and complexities, including several plumbers groups. The wisdom we've gained is that **each is unique, and we need to be flexible and detailed in our planning when implementing each group.** Our seasoned group of implementation experts researches, prepares for and embraces each client's attributes and culture to ensure success.

Bottom line: We're committed to doing the right thing for the right reason, which is why you can trust us to do what we say we'll do for you and your retirees.

"From day one, Aetna joined us on the ground in our retirees' local communities.

And now, 99% of our members are satisfied."

– Senior benefits director at State of New Jersey

"My Executive Committee asked me to let you know how impressed and appreciative they are of the well-prepared presentations you so expertly gave about our insurance change. As educators, not only were we listening to the content of your presentation, but also we could not help but to 'evaluate' your patience and ability to handle confrontational attendees. Truthfully, we were rooting for you at all times and **without question you earned an A+++.**"

– President of statewide union, State of New Jersey

"**Aetna** has been a health insurance provider for Ohio SERS enrollees since the 1970s. Around 2016, a majority of SERS' pre-Medicare retirees were transferred to Aetna, with positive savings results. More recently, the Board of Directors approved the transfer of all Medicare retirees to Aetna to improve both enrollee and plan sponsor cost savings. SERS has a long relationship with Aetna and its Account team; we find them responsive, collaborative partners administratively and in service to our enrollees. SERS is preparing to enter into another 5-year agreement with improved terms on behalf of our retirees and employees."

— Christi Pepe, Director of Health Care, School Employee Retirement System of Ohio

5

Our consistently high quality also helps lower your costs

100% of your retirees will be in our 4.5 Star plan and they will feel the quality.

We have an enduring commitment to quality in our Medicare plans, evident through our persistently high Star Ratings.

At 4.5 Stars, we've maximized CMS risk revenue to offer a more sustainable program. Our consistently high Star Ratings enable us to reduce plan premiums and invest in new programs that improve wellness.

Each year, **we make substantial investments in quality improvements with great results**. In 2021, 4.8M Stars gaps in care were closed for our MA members, which means their health needs were more effectively addressed.[5]

4.5 Stars

★★★★½

2022 Star Rating — at the forefront of maximizing CMS revenue and quality of care[6]

PROPOSAL HIGHLIGHTS

- **Significant and sustainable savings with Aetna's MAPD solution**
- **Performance guarantees with 1% premium at risk**
- **Enhanced benefits including Resources for Living, Healthy Home Visits, SilverSneakers, meals, transportation, Healthy Rewards and more**

5 CVS Health enterprise data analysis, as of February 2022.
6 Based on 2022 Star Ratings data published by CMS on October 8, 2021. CMS evaluates plans based on a 5-Star rating system. Star Ratings are calculated each year and may change from one year to the next. Our Overall Part C and Part D rating is 4.5 Stars.

Our promise to you

We're proud to serve our retirees — 80% of whom are public and labor — and we commit to partner with you and deliver on the promises made in this RFP response.

As one of the largest national health care companies in the US, we're committed to improving the health of our members by leveraging our unmatched local presence, a valuable asset enabling us to deliver over 50 million COVID-19 vaccinations and provide care through our stores and care services team.

We are fully committed to you and your retirees. Our combined strengths and vision can transform health care, delivering an unparalleled experience and ensuring that quality care and retiree savings go hand in hand.

We look forward to building on our strong foundation with you and delivering a full new range of assets and expertise , demonstrating our value and full commitment to you and your retirees.

1. **Delivering the advantages of a hyperlocal footprint to you and your retirees**
   Our unparalleled suite of assets drives better engagement and sustainability
2. **Creating a partnership based on trust and competence**
   You can trust us to work with integrity and competence and do what we say we'll do
3. **Our deep experience improving sustainability with groups like yours**
   By tapping into our experience and assets, we deliver a better cost framework to you

Richard A. Frommeyer

Rick Frommeyer
Senior Vice President,
Aetna Group Retiree Solutions

Wendy M. Smitherman

Wendy Smitherman
Vice President,
Aetna Group Retiree Solutions

aetna®

MINIMUM QUALIFICATIONS

The following are mandatory requirements for all proposers that cannot be delegated to another entity and must be met by the actual entity submitting the proposal. Failure to meet any of these requirements at the time of the submission deadline will result in the disqualification of a proposal:

1. Proposer must be properly licensed in Louisiana. Please provide copies of all licensing credentials.

   Confirmed. Please refer to the enclosed State Insurance License in our proposal response.

2. Proposer must have at least five (5) years of experience in providing the type of plans and services requested in this SOQ.

   Confirmed.

3. Proposer must offer the type of plans and services as described in this SOQ to at least two (2) similar employer groups or municipalities with similar total members as Jefferson Parish Government, and provide as references

CONFIDENTIAL

Spotsylvania County Public Schools, Fredericksburg, VA
Vera Fox, Human Resources Assistant
vfox@spotsylvania.k12.va.us
540-834-2500, ext. 1500

Caddo Parish Sheriff's Office
Jobie Moore, Chief Administrative Officer
Office: 318-681-0823
Fax: 318-681-0888
jobie.moore@caddosheriff.org

Bossier Parish Sheriff's Office
P.O. Box 850
Benton, LA 71006
Phone: 318-965-3476
Email: ceubanks@bossiersheriff.com

CONFIDENTIAL

EVALUATION CRITERIA

1. Financial Proposals – 30 points maximum
2. Demonstrated experience providing quality medical and pharmacy plan benefits for large groups (1,000+ members) – 20 points maximum
3. Company's financial strength – 10 points maximum
4. Demonstrated ability to provide excellent customer service to the Plan Administrator and Members – 20 points maximum
5. Benefit Structure, Nationwide provider network, Dental Benefits, Vision Benefits, Other Value-Added Benefits – 20 Points maximum

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Confirmed.

The person or firm submitting a Statement of Qualification (General Professional Services Questionnaire) must identify all subcontractors who will assist in providing professional services for the project, in the professional services questionnaire. Each subcontractor shall be required to submit a General Professional Services Questionnaire and all documents and information included in the questionnaire. (Refer to Jefferson Parish Code Ordinance, Section 2-928)

All persons or firms (including subcontractors) must submit a Statement of Qualifications (General Professional Services Questionnaire) by the deadline. The latest professional services questionnaire may be obtained by contacting the Purchasing Department at (504) 364-2678 or via the Jefferson Parish website at www.jeffparish.net. This questionnaire can be accessed by hovering over "Business and Development" on the website and clicking on the Professional Services Questionnaires option under "Doing Business in Jefferson Parish".

Please see attached *Aetna Medicare Vendor List*. Per communication from Jefferson Parish, vendors do not work under the direct supervision of Aetna, and therefore would not need to submit questionnaires or contracts.

Submissions will only be accepted electronically via Jefferson Parish's e-Procurement site, Central Bidding at www.centralauctionhouse.com or www.jeffparishbids.net. Registration is required and free for Jefferson Parish vendors by accessing the following link: www.centralauctionhouse.com/registration.php .

Confirmed.

No submittals will be accepted after the deadline.

Confirmed.

Affidavits are not required to be submitted with the Statement of Qualifications, but shall be submitted prior to contract approval.

Confirmed.

Disputes/protests relating to the decisions by the evaluation committee or by the Jefferson Parish Council shall be brought before the 24th Judicial Court.

Confirmed.

SCOPE OF SERVICES

General Services

Mail all plan related materials to all covered retirees to be received prior to commencement of open enrollment meetings on an annual basis. Materials will include plan summary, all inclusive network provider list/booklet, prescription drug coverage information, material describing ancillary coverage, such as dental, vision, etc.

Will comply with all applicable Federal, State, and Local laws, rules and regulations. These laws, rules and regulations will be deemed to be included in the contract the same as though herein written in full.

The healthcare provider must mail subscriber and dependent ID cards annually prior to the first of each year after open enrollment.

Provide annual open enrollment support by providing a speaker at each retiree meeting upon request. Provide representatives to meet with retirees individually upon request for possible enrollment when the retiree reaches age 65.

Confirmed.

Professional Services

Provide a network of physicians, hospitals and ancillary medical providers. Maintain a thorough, well documented credentialing procedure, and conduct an ongoing quality assurance program under the purview of a peer review committee.

Provide utilization management services designed to authorize care with the fewest number of hospital days and/or elective surgeries such that quality of care and patient satisfaction are not reduced. Reviews to be conducted by staff consisting of registered nurses and a panel of physician advisors including specialists.

Provide information on all programs that target treatment of chronic diseases, i.e., disease management. Discuss health assessment surveys, nurse interventions and health outcome data, different therapies used to treat different diseases and dissemination of data to network physicians.

Confirmed.

Administrative Services

Establish, maintain, and update Master Record file(s). Prepare and print all plan documents:

- Group Policy/ Plan Document
- Summary Plan Description (SPD)
- Other documents as may be required by federal state and local laws

Furnish all standard forms to be used in connection with the administration of the plan:

- Enrollment Forms
- Claim Forms
- lD cards
- EOBs

Review, in a consultative capacity, summary plan descriptions and other similar material to be distributed to plan participants.

Consult on plan provisions, plan design, impact of local, state, or federal legislation, new medical procedures/technology, emerging benefits trends, cost containment, and other ongoing services issues.

Confirmed.

Performance Standards

Proposer shall maintain the following performance levels, as applicable:

Eligibility Loading- Load all eligibility files into system within five (5) business days of receipt. Measurement Criteria- Elapsed time from date file received to the date upon which the file is loaded to the eligibility system.

ID Cards -mailed within ten (10) business days after final member eligibility is received, system loaded and passes a quality assurance check. Measurement Criteria - Date ID cards are mailed.

Electronic "Claim Ready Date"- Electronic Claim Ready by the effective date or within twenty (20) business days after account structure is entered into the system, final member eligibility is received, and benefit plan design is finalized. Measurement Criteria - Date plan benefits and employee and dependent eligibility data is system loaded.

Claim Operations: Measurement Criteria- by standard claim operations reports:

Time to Pay- 90% of "non-controversial' or "clean" claims paid in ten (10) business days Financial Accuracy- 99% of submitted charges processed correctly

Procedural Accuracy- 95% of claims processed without non-financial error
Penalties: The annual penalty for failure to maintain the performance levels above shall be:

Eligibility Loading	$20,000
ID Cards	$50,000
Electronic "Claims Ready Date”	$50,000

Time to pay $50,000 for failure to pay 90% of claims within 10 days; Increase $5,000 per extra day to meet 90% standard to a maximum of 15 days and maximum of$100,000.

Financial Accuracy $100,000 for failure to process 99% of claims correctly; Increase $5,000 per 25% reduction in accuracy to 98% and maximum of $200,000

Procedural Accuracy $20,000 for failure to process 95% of claims without a Non- financial error; increase $5,000 per .50% reduction in accuracy to 93% and maximum of $40,000.

Please see the 2023 MAPD Performance Guarantees document of our proposal response for our proposed guarantees.

Claims Processing Services

Maintain and update eligibility file.

Administer the plans' Coordination of Benefits (COB) provision.

Review claims submitted for medical services that appear excessive and/or establish medical necessity for services rendered or expenses incurred.

Make available the services of field claim consultants and/or professional services resources for the evaluation of complex claims.

Maintain peer review relations.

Discuss disputed charges with providers when appropriate.

Must notify JPG of any and all PPACA changes and updates that will impact JPG financially and administratively.

Maintain and store claim detail data elements for statistical

analysis. Provide online and mobile claim viewing access to

participants.

Confirmed.

New Business Installation Services

Consult on new products, alternate health care delivery system, and healthcare cost management techniques.

Participate in and/or conduct retiree meetings as requested.

Act as a liaison with administrative, technical services, and claims departments.

If you are awarded the contract, you will be responsible for developing, printing and distribution of the required ID cards, claim forms, provider directories and employee booklets. Any cost for these services must be absorbed by the proposer.

Confirmed.

Other Services

Provide a network of physicians, hospitals and other health care professionals and providers offering discounts or special fee arrangements to their normal service fee schedules.

A dedicated nationwide toll free customer service line specifically for retirees of the Parish is required.

JPG reserves the right to return to the top candidates to request a final proposal based on one or more components of the initial proposal. JPG reserves the right to negotiate certain terms and conditions relative to the contract.

Confirmed.

SCHEDULE OF EVENTS

Action	Target Date
Released to Insurance Carriers	7/20/2022
Proposal Submitted to JPG	8/18/2022
Successful Carrier Selected	TBD
Successful Carrier Contract Ratified	TBD
Effective Date	01/01/2023

Note: Jefferson Parish reserves the right to deviate from these dates.

Confirmed.

LIST OF ATTACHMENTS

The following attachments are made a part of this SOQ. Please respond completely to all as indicated.

Attachment A	General Professional Services Questionnaire
Attachment B	Insurance Requirements and Indemnification
Attachment C	Proposed Rate Form
Attachment D	Carrier Questionnaire
Attachment E	SOQ Affidavit

Confirmed.

ATTACHMENT B

INDEMNITY

To the fullest extent permitted by law, Proposer, agrees to protect, defend, indemnify and save the Parish, its agents, officials, employees, volunteers or any firm, company, organization, or individual, or their Proposers, or subcontractors with whom the Parish may be contracted harmless from and against any and all claims, demands, actions, and causes of action of every kind and character including but not limited to claims based on negligence, strict liability, and absolute liability which may arise in favor of any person or persons on account of illness, disease, loss of property, services, wages, death or personal injuries resulting from acts or omissions of Proposer, its agents, employees, assigns, or subcontractors, during the operations contemplated by the contract.

This indemnity does not extend to the sole negligence of the Parish and the Proposer shall not be liable to the Parish for its lost profits or revenue or consequential damages except claims advanced in tort and/or claims advanced in contract due to the bad faith of Proposer. Bad faith shall mean a breach of some motive or interest of ill will on the part of the Proposer.

Further, Proposer hereby agrees to indemnify the Parish for all reasonable expenses including but not limited to all fees and charges of attorneys and other professionals and all court or other dispute resolution costs incurred by or imposed upon the Parish in connection therewith for any such loss, damage, injury or other casualty. Proposer further agrees to pay all reasonable expenses and attorneys' fees incurred by the Parish in establishing the right to indemnity pursuant to the provisions in this agreement."

The insurance requirements shall be as follows:

All insurance requirements shall conform to Jefferson Parish Resolution No. 113646 dated 12/09/2009.
The proposer shall not commence work under this contract until it has obtained all insurance and complied with the insurance requirements of the specifications and Resolution No. 113646.

<u>WORKER'S COMPENSATION INSURANCE</u>
As required by Louisiana State Statute, except Employer's Liability, Section B shall be $1,000,000 per occurrence when Work is to be over water and involves maritime exposures to cover all employees not covered under the State Worker's Compensation Act; otherwise, this limit shall be no less than $500,000 per occurrence.

COMMERCIAL GENERAL LIABILITY
Shall provide limits not less than the following: $1,000,000.00 Combined Single Limit per Occurrence for bodily injury and property damage.

COMPREHENSIVE AUTOMOBILE LIABILITY
Bodily injury liability $1,000,000.00 each person; $1,000,000.00 each occurrence. Property Damage Liability $1,000,000.00 each occurrence.
DEDUCTIBLES
No insurance required shall include a deductible greater than $10,000.00. The cost of the deductible is borne by the Proposer.

PROFESSIONAL LIABILITY
Shall provide Combined Single Limit of $1,000,000.00 per Occurrence.

UMBRELLA LIABILITY COVERAGE
An umbrella policy or excess may be used to meet minimum requirements.

SUBCONTRACTOR INSURANCE
The Proposer shall include all subcontractors as insured's under its policies or shall insure that all subcontractors satisfy the same insurance requirements stated herein for the Proposer.

Indemnity

Our fully-insured contracts do not provide for indemnification as we bear the entire risk. Also, as claim fiduciary under full-risk plans, we are responsible for final claim decisions consistent with federal law and regulations and, thus, we have the primary responsibility for defending those decisions in lawsuits for plan benefits including settlement of such lawsuits.

Other than in an action between the parties for third party indemnification, neither party shall be liable to the other for any consequential, incidental or punitive damages whatsoever.

Comprehensive automobile liability

Aetna is unable to comply with this requirement as all of our Deductible and Retentions exceed $10,000 which is commercially reasonable for a company of our size and financial strength.

Professional liability

Professional Liability policy is written on a 'claims-made' form rather than occurrence based.

Subcontractor insurance

Aetna requires subcontractors to maintain adequate insurance coverage, with limits commensurate with the nature and scope of the services being performed by such Subcontractor. Aetna is unable to ensure that those meet or exceed all requirements stated herein.

Statement of Qualifications
Affidavit Instructions

- **Affidavit is supplied as a courtesy to Affiants, but it is the responsibility of the affiant to insure the affidavit they submit to Jefferson Parish complies, in both form and content, with federal, state and parish laws.**
- **Affidavit must be signed by an authorized representative of the entity or the affidavit will not be accepted.**
- **Affidavit must be notarized or the affidavit will not be accepted.**
- **Notary must sign name, print name, and include bar/notary number, or the affidavit will not be accepted.**
- **Affiant MUST select either A or B when required or the affidavit will not be accepted.**
- **Affiants who select choice A must include an attachment or the affidavit will not be accepted.**
- **If both choice A and B are selected, the affidavit will not be accepted.**
- **Affidavit marked N/A will not be accepted.**
- **It is the responsibility of the Affiant to submit a new affidavit if any additional campaign contributions are made after the affidavit is executed but prior to the time the council acts on the matter.**

Instruction sheet may be omitted when submitting the affidavit

Statement of Qualifications

AFFIDAVIT

STATE OF Connecticut

PARISH/COUNTY OF Hartford

BEFORE ME, the undersigned authority, personally came and appeared: _____

Tami Polsonetti, (Affiant) who after being by me duly sworn, deposed and said that he/she is the fully authorized Assistant Vice President of Aetna Life Insurance Company (Entity), the party who submitted a Statement of Qualifications (SOQ) to _____

SOQ 22-021 - Fully Insured Medical Plans (Briefly describe the services the SOQ will cover), to the Parish of Jefferson.

Affiant further said:

Campaign Contribution Disclosures

(Choose A or B, if option A is indicated please include the required attachment):

Choice A _____ Attached hereto is a list of all campaign contributions, including the date and amount of each contribution, made to current or former elected officials of the Parish of Jefferson by Entity, Affiant, and/or officers, directors and owners, including employees, owning 25% or more of the Entity during the two-year period immediately preceding the date of this affidavit or the current term of the elected official, whichever is greater. Further, Entity, Affiant, and/or Entity Owners have not made any contributions to or in support of current or former members of the Jefferson Parish Council or the Jefferson Parish President through or in the name of another person or legal entity, either directly or indirectly.

Choice B X there are **NO** campaign contributions made which would require disclosure under Choice A of this section.

Affiant further said:

Debt Disclosures

(Choose A or B, if option A is indicated please include the required attachment):

Choice A _____ Attached hereto is a list of all debts owed by the affiant to any elected or appointed official of the Parish of Jefferson, and any and all debts owed by any elected or appointed official of the Parish to the Affiant.

Choice B X There are **NO** debts which would require disclosure under Choice A of this section.

Affiant further said:

Solicitation of Campaign Contribution Disclosures

(Choose A or B, if option A is indicated please include the required attachment):

Choice A _____ Attached hereto is a list of all elected officials of the Parish of Jefferson, whether still holding office at the time of the affidavit or not, where the elected official, individually, either by **telephone or by personal contact,** solicited a campaign contribution or other monetary consideration from the Entity, including the Entity's officers, directors and owners, and employees owning twenty-five percent (25%) or more of the Entity, during the two-year period immediately preceding the date the affidavit is signed. Further, to the extent known to the Affiant, the date of any such solicitation is included on the attached list.

Choice B X there are **NO** solicitations for campaign contributions which would require disclosure under Choice A of this section.

Affiant further said:

Subcontractor Disclosures

(Choose A or B, if option A is indicated please include the required attachment):

Choice A _____ Affiant further said that attached is a listing of all subcontractors, excluding full time employees, who may assist in providing professional services for the aforementioned SOQ.

Choice B X There are **NO** subcontractors which would require disclosure under Choice A of this section.

Affiant further said:

That Affiant has employed no person, corporation, firm, association, or other organization, either directly or indirectly, to secure the public contract under which he received payment, other than persons regularly employed by the Affiant whose services in connection with the construction, alteration or demolition of the public building or project or in securing the public contract were in the regular course of their duties for Affiant; and

[*The remainder of this page is intentionally left blank.*]

That no part of the contract price received by Affiant was paid or will be paid to any person, corporation, firm, association, or other organization for soliciting the contract, other than the payment of their normal compensation to persons regularly employed by the Affiant whose services in connection with the construction, alteration or demolition of the public building or project were in the regular course of their duties for Affiant.

Signature of Affiant

Tami Polsonetti

Printed Name of Affiant

SWORN AND SUBSCRIBED TO BEFORE ME

ON THE 11 DAY OF August, 20 22.

Notary Public

Pamela J. Heeps

Printed Name of Notary

Not applicable

Notary/Bar Roll Number

PAMELA J. HEEPS
NOTARY PUBLIC
My Commission Expires May 31, 2026

My commission expires May 31, 2026.

SOQ 22-037 - Group Medicare Advantage Plan with a Nationwide Provider Network for all Medicare Eligible Retirees and Dependents

Jefferson Parish Government

General Professional Services Questionnaire Instructions

- The General Professional Services Questionnaire shall be used for all professional services except outside legal services and architecture, engineering, or survey projects.
- **The General Professional Services Questionnaire should be completely filled out. Complete and attach ALL sections. Insert "N/A" or "None" if a section does not apply or if there is no information to provide.**
- Questionnaire must be signed by an authorized representative of the Firm. Failure to sign the questionnaire shall result in disqualification of proposer pursuant to J.P. Code of Ordinances Sec. 2-928.
- All subcontractors must be listed in the appropriate section of the Questionnaire. Each subcontractor must provide a complete copy of the General Professional Services Questionnaire, applicable licenses, and any other information required by the advertisement. Failure to provide the subcontractors' complete questionnaire(s), applicable licenses, and any other information required by the advertisement shall result in disqualification of proposer pursuant to J.P. Code of Ordinances Sec. 2-928.
- If additional pages are needed, attach them to the questionnaire and include all applicable information that is required by the questionnaire.

General Professional Services Questionnaire

A. Project Name and Advertisement Resolution Number:

Group Medicare Advantage Plan with a Nationwide Provider Network for all Medicare Eligible Retirees and Dependents.

SOQ No. 22-037

B. Firm Name & Address:

Aetna Life Insurance Company
151 Farmington Ave.
Hartford, CT 06156

C. Name, title, & contact information of Firm Representative, as defined in Section 2-926 of the Jefferson Parish Code of Ordinances, with at least five (5) years of experience in the applicable field required for this Project:

Wendy Smitherman
Vice President, Client Solutions, Aetna Group Medicare
SmithermanW@aetna.com
336-345-9534

D. Address of principal office where Project work will be performed:

Aetna Life Insurance Company
151 Farmington Ave.
Hartford, CT 06156

E. Is this submittal by a JOINT-VENTURE? Please check:

YES _____ NO __X____

If marked "No" skip to Section H. If marked "Yes" complete Sections F-G.

F. If submittal is by JOINT-VENTURE, list the firms participating and outline specific areas of responsibility (including administrative, technical, and financial) for each firm. Please attach additional pages if necessary.

1. N/A

General Professional Services Questionnaire

2.

G. Has this JOINT-VENTURE previously worked together? Please check: YES _____ NO _____

H. List all subcontractors anticipated for this Project. Please note that all subcontractors must submit a fully completed copy of this questionnaire, applicable licenses, and any other information required by the advertisement. See Jefferson Parish Code of Ordinances, Sec. 2-928(a)(3). Please attach additional pages if necessary.

Name & Address:	Specialty:	Worked with Firm Before (Yes or No):
1. Please see attached *Aetna Medicare Vendor List*. Per communication from Jefferson Parish, vendors do not work under the direct supervision of Aetna, and therefore would not need to submit questionnaires or contracts.		
2.		
3.		
4.		

General Professional Services Questionnaire

I. Please specify the total number of support personnel that may assist in the completion of this Project:
20+

J. List any professionals that may assist in the completion of this Project. If necessary, please attach additional documentation that demonstrates the employment history and experience of the Firm's professionals that may assist in the completion of this Project (i.e. resume). Please attach additional pages if necessary.

PROFESSIONAL NO. 1

Name & Title:

Kurt Hoglund, Senior Account Manager

Name of Firm with which associated:

Aetna

Description of job responsibilities:

The Account Manager (AM) is the day-to-day contact to help ensure we meet all our plan sponsor's needs and resolve any issues which may arise. The AM also navigates the systems needed to ensure billing, enrollment and claims are all working correctly and is the primary point of contact for our plan sponsors.

Your AM will be your primary point of contact. In addition to supporting your day-to-day needs, the AM will support the communication strategy for any new plan changes or as part of a new plan implementation.

Years' experience with this Firm:

4

Education: Degree(s)/Year/Specialization:

Western Illinois University

Other experience and qualifications relevant to the proposed Project:

Kurt Hoglund is a group retiree market senior account manager with Aetna. He joined Aetna and Group Retiree Solutions in August 2021.

Kurt has over 10 years' experience in the Medicare-related health insurance industry. For 7 years, Kurt worked as a licensed sales agent for Aon Retiree Health Solutions. For 2 years, he helped Medicare beneficiaries find and enroll in health insurance to go along with their Original Medicare (Medicare Advantage, Medicare Supplement, Medicare Part D, dental and vision). Kurt was then promoted to sales manager and managed a team of 15-20 sales agents for 5 years before joining CVS Health in 2018 as an account manager for SilverScript Medicare Part D Employer Group Waiver Plan (EGWP) clients.

As a senior account manager in Aetna Group Retiree Solutions, Kurt directs Aetna's internal team to achieve excellent account service and develop solutions for retiree plan management. He has principal responsibility and oversight for client service functions such as account management, training, maximizing client growth, retention and guiding clients through the renewal process.

General Professional Services Questionnaire

PROFESSIONAL NO. 2
Name & Title:
Anthony Kemp, Plan Sponsor Liaison
Name of Firm with which associated:
Aetna
Description of job responsibilities:
An Aetna Medicare Plan Sponsor Liaison (PSL) will support Jefferson Parish and will serve as your single point of contact. The Medicare PSL acts as a primary point of contact for you and our sales teams for member-specific items and broader plan administration. Your Medicare PSL works to streamline your experience and help with a smooth implementation and benefits installation. Working with your Account Manager, the Medicare PSL will be fully engaged in the implementation process and site visits, will identify urgent business issues and will work to develop a course of action for optimal solutions.
Years' experience with this Firm:
9
Education: Degree(s)/Year/Specialization:
High school diploma and 9 years of Medicare industry experience.
Other experience and qualifications relevant to the proposed Project:
As a Plan Sponsor Liaison, Anthony will be your single point of contact for all customer inquiries, membership reporting requests, own all ID card processes and will build group specific tools utilized by Aetna customer service. He will work closely with your Account Manager to find creative solutions to all inquiries and trends related to claims, enrollment/eligibility and benefits. Anthony began his Medicare healthcare career in August 2013 as a Plan Sponsor Service Consultant with the Medicare Pend Team. Researching and resolving rejected member applications. He transitioned to the role of Plan Sponsor Liaison in May 2017. Prior to Aetna, Anthony's professional background includes working as Resale Disclosure Coordinator, Photo Lab Manager and Certified Nurses Aide. Throughout his Aetna career, Anthony has been nominated and has been Employee of the Month. He has completed his ABX courses for the White and Yellow Belt certification. He continue to use root cause analysis for problem solving.

General Professional Services Questionnaire

PROFESSIONAL NO. 3

Name & Title:

Nicki Hollerich, Implementation Manager

Name of Firm with which associated:

Aetna

Description of job responsibilities:

Your implementation managers are responsible for the following:

- Oversee the implementation process for Medicare Advantage (MA) customers
- Coordinate all implementation activities (meetings, conference calls, etc.)
- Provide documentation to the implementation team (varies depending on assigned level of support)
- Identify and procure resources needed for the project's scope

In addition, your implementation manager is responsible for team building, communication, resource management, problem solving and planning. They will facilitate review of plan sponsor requirements with appropriate business areas for impact to downstream systems and communicate the results to the team and the plan sponsor as necessary. They will meet with the sales and operation teams as needed or requested to the outline scope of project and expectations. They will also ensure key relationships are in place prior to sign-off which is typically 30 to 60 days after the effective date.

Years' experience with this Firm:

5

Education: Degree(s)/Year/Specialization:

High school diploma and 32 years of insurance industry experience

Other experience and qualifications relevant to the proposed Project:

- 32 years healthcare industry experience, including life & health licensed from 11/2004 – 8/2020
- Results-driven through personal initiative and positive motivation of associates
- Solid communication, documentation and problem solving skills
- Methodical and detail-oriented approach to the tasks assigned, while adhering to deadlines
- Ability to effectively define issues, collect data, establish facts, and draw valid conclusions
- Able to operate autonomously and make key decisions
- Skilled at balancing multiple demands and/or projects in a high pressure environment.

General Professional Services Questionnaire

K. List all prior projects that best illustrate the Firm's qualifications relevant to this Project. Please include any and all work performed for Jefferson Parish. Please attach additional pages if necessary.	
PROJECT NO. 1	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
As a professional courtesy to our customers, we seek their permission in each instance we use their names as a reference. May of our customers ask we release their names only when we are a finalist. We are happy to supply the remaining references upon being named a finalist. Please see the references in **Attachment D**.	
Length of Services Provided:	**Cost of Services Provided:**

General Professional Services Questionnaire

PROJECT NO. 2	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
Length of Services Provided:	**Cost of Services Provided:**

General Professional Services Questionnaire

PROJECT NO. 3	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
Length of Services Provided:	**Cost of Services Provided:**

PROJECT NO. 4	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
Length of Services Provided:	**Cost of Services Provided:**

General Professional Services Questionnaire

PROJECT NO. 5	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
Length of Services Provided:	**Cost of Services Provided:**

PROJECT NO. 6	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
Length of Services Provided:	**Cost of Services Provided:**

General Professional Services Questionnaire

PROJECT NO. 7	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
Length of Services Provided:	**Cost of Services Provided:**

PROJECT NO. 8	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
Length of Services Provided:	**Cost of Services Provided:**

General Professional Services Questionnaire

PROJECT NO. 9	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
Length of Services Provided:	**Cost of Services Provided:**

PROJECT NO. 10	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
Length of Services Provided:	**Cost of Services Provided:**

General Professional Services Questionnaire

L. List all prior and/or on-going litigation between Firm and Jefferson Parish. Please attach additional pages if necessary.

Parties:		Status/Result of Case:
Plaintiff:	**Defendant:**	
1.		*Aetna Life Insurance Company (ALIC) may be involved in regulatory actions and litigation regarding the administration of our businesses. Due to the size of our business, non-material government, regulatory or administrative investigations, proceedings, complaints, lawsuits or other legal proceedings naturally flow from disputes that arise out of the sensitive nature of services provided by a managed care organization. ALIC is an indirect wholly owned subsidiary of CVS Health Corporation. We disclose significant regulatory actions in our parent company's SEC filings. This information is available on our website. We haven't been disbarred or precluded in any way from doing business in any state. We work diligently and expeditiously to resolve issues that arise as a result of administering or insuring benefit plans for our customers.
2.		*
3.		*
4.		*

M. Use this space to provide any additional information or description of resources supporting Firm's qualifications for the proposed project.

General Professional Services Questionnaire

We have many years of experience working with plan sponsors to assist their retirees in making the best selection for their health plan and prescription drug plan needs. We will work closely with your retirees to help ensure a smooth transition process. We are there to assist in any way possible and are confident in our abilities to create and demonstrate a seamless transition for your retirees.

Aetna's implementation strategy takes a team approach to client implementation that coordinates people, activities and deadlines. These activities begin even before our confirmation as the new carrier. The implementation process begins with the assignment of a Medicare Implementation Project Manager and assembling the Account Management team assigned to Jefferson Parish. Subject matter experts, dedicated to group retiree services, also join the team.

We utilize a sophisticated, in-house software system — Customer Implementation Management System (CIMS) which we developed. It is a unique project management tool that helps our implementation teams prepare customized project management documents such as time and resource estimates, Gantt charts and specific task assignments.

The project manager will identify any cross-functional dependencies and coordinate completion and timing of the project. We integrate all project tasks to provide retirees with a smooth transition that begins months before the start of open enrollment and continues into post-enrollment support.

N. To the best of my knowledge, the foregoing is an accurate statement of facts.

Signature: _____ **Print Name:** Tami Polsonetti

Title: Executive Director, Sales Support **Date:** August 16, 2022

ATTACHMENT D

CARRIER QUESTIONNAIRE

1. Name and address of parent company and local office.

The ultimate parent of all Aetna affiliated companies is CVS Health Corporation, a publicly traded, Delaware corporation. CVS Health Corporation's corporate headquarters are located Woonsocket, RI.

Your local office is located in Metairie, LA. The address is 3838 N Causeway Blvd, Metairie, LA 70002.

2. Is your company a wholly-owned subsidiary or a division of another company? If so, please identify the company name and address.

Aetna Inc. is an indirect subsidiary of CVS Health Corporation, the publicly traded parent company of the Aetna group of companies. The subsidiaries of the Aetna group of companies include insurance companies, such as:

- Aetna Life Insurance Company (ALIC)
- HMOs
- DMOs®
- Companies that maintain TPA and other licenses

CVS Health Corporation's corporate headquarters are located Woonsocket, RI.

The address of CVS Health Corporation's corporate headquarters is One CVS Drive, Woonsocket, RI 02895.

3. How many members are currently being served nationally and in Louisiana? How many employers with over 1000 retirees are currently being served?

We are currently serving 3,118,142 Medicare Advantage members nationally, and 10,204 in the State of LA.

We currently have 77 Group Medicare Advantage clients with over 1,000 retirees.

4. Provide three references that have similar dynamics to Jefferson Parish Government. At least one reference group should have gone through the respective enrollment process within the last two years. Include contact names, phone numbers and email addresses.

CONFIDENTIAL

Spotsylvania County Public Schools, Fredericksburg, VA
Vera Fox, Human Resources Assistant
vfox@spotsylvania.k12.va.us
540-834-2500, ext. 1500

Caddo Parish Sheriff's Office
Jobie Moore, Chief Administrative Officer
Office: 318-681-0823
Fax: 318-681-0888
jobie.moore@caddosheriff.org

Bossier Parish Sheriff's Office
P.O. Box 850
Benton, LA 71006
Phone: 318-965-3476
Email: ceubanks@bossiersheriff.com

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5. How long has your company been in business?

Aetna is a leading diversified health care benefits company with more than 165 years of experience in providing quality, reliable services to businesses, individuals and the government. Founded in 1853 in Hartford, CT, we entered the group health insurance business in 1936.

6. What is your AM Best Rating? If applicable.

Our current A.M. Best Rating is an A.

7. What is the size of your local staff?

We have 361 employees in the state of Louisiana.

8. Provide a resume for each key employee in your organization who will be handling our account.

We identify members of the account team during the finalist stage of the proposal process.

9. List three references of over 1,000 retirees' who you administer the health plan. Please provide employer, contact, address and phone number of references.

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Spotsylvania County Public Schools, Fredericksburg, VA
Vera Fox, Human Resources Assistant
vfox@spotsylvania.k12.va.us
540-834-2500, ext. 1500

Caddo Parish Sheriff's Office
Jobie Moore, Chief Administrative Officer
Office: 318-681-0823
Fax: 318-681-0888
jobie.moore@caddosheriff.org

Bossier Parish Sheriff's Office
P.O. Box 850
Benton, LA 71006
Phone: 318-965-3476
Email: ceubanks@bossiersheriff.com

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10. Describe the account management services and the team that would be responsible for handling the Parish account.

We support you with a consultative account team that works with you to achieve the best possible success for you and your benefit goals. And your team supports you by bringing new solutions to round out your overall benefit experience.

Our goal is to be your trusted advisor. That's why your account team includes a Vice President of Client Management, Account Executive, Account Manager and Plan Sponsor Liaison. Jefferson Parish's account team serves as an extension of your internal benefit and leadership teams, working directly with you to collaborate on strategy, drive results and simplify plan administration.

We work with you to define success and the roadmap to get there. Together, we customize your plan to meet your exact needs and ensure those needs are met in the most cost-effective and efficient way possible. Your account team:

- Understands your objectives and is a true strategic partner and trusted advisor, creating integrated strategies to achieve the best results for your employees and their families
- Monitors data for trends, alerts you to any problems and proposes strategic solutions to address any barriers to success
- Builds trend reduction initiatives to ensure your plan remains cost-effective and provides the maximum financial benefit
- Provides you with the right data and information to help you best understand and manage your benefits plan along with customized analytics to support your specific plan and productivity strategy
- Solves any challenges to plan administration and works closely with you to demonstrate the full value of the programs and services included in your benefit plan

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11. Describe the support you would provide as part of a change in vendors. Provide an implementation and communication schedule showing tasks, allocation of responsibilities and personnel.

Please see the attached *Jefferson Parish Implementation Plan.* Aetna has a full implementation services package that includes timelines, milestone dates, full project plans and a comprehensive schedule of meetings and conference calls. We take a team approach to plan sponsor implementation that coordinates people, activities and deadlines. These services begin even before our confirmation as the new carrier. Our implementation process offers our customers four key advantages:

- **Customer Implementation Management System (CIMS)** – a sophisticated, in-house software system which we developed. It is a unique project management tool that helps our implementation teams prepare customized project management documents such as time and resource estimates, Gantt charts and specific task assignments.

- **Consistency** – our implementation team members include individuals who will provide services for our customers even after implementation.
- **A customized implementation management plan** – we tailor our implementation plan around your specific needs and goals.
- **Dedicated project management** - following the project launch, we finalize the project plan and the teams begin working on tasks in their various areas. The project manager will identify cross-functional dependencies and coordinate completion and timing of the project. The project manager integrates all project tasks to give retirees a smooth transition that begins months before the start of open enrollment and continues into post-enrollment support.

We will develop a detailed implementation plan tailored to Jefferson Parish's specific needs and objectives. The plan includes a detailed timeline to ensure we implement flawlessly. The plan timeline details the scheduled activities and dates to ensure we document all tasks and assign those tasks to a specific area. The plan also includes communications strategies and approvals, eligibility discussions that include account structure, Medicare Beneficiary Identification (MBI) validation, age-in process and billing and customer service for both pre- and post-enrollment. The implementation manager monitors the tasks and timeline to ensure readiness on the effective date.

Communications

Effective communications and education are critical in helping your retirees make the best decisions about their health plan and personal health. Aetna's specialized Group Retiree Communications team, along with your account management team, will work closely with Jefferson Parish to build a communication solution that fits your needs, as well as the needs of your retirees. In addition, these teams ensure that all Aetna Medicare communication materials follow strict Centers for Medicare & Medicaid Services (CMS) rules.

We include this communication program at no cost to you, as part of our commitment to you and your retirees. Understanding that each plan sponsor is unique, we carefully review your specific retiree offering situation and communication needs. We then recommend a communication plan based on that review.

Communication and education based on proven best practices and research

Years of analysis of both our own campaigns and third-party research provide insight into retiree wants, needs, concerns, attitudes and behavior regarding their health plan understanding, selection and usage. Our communications team uses this information to create effective education materials to help your retirees more easily choose and use their health benefits.

We strongly recommend that our communications be co-branded with your name and logo. This is important to your retirees' understanding that our communication is specific to the Aetna group plan you offer, rather than an "unsolicited" open-market promotion. Timing recommendations will be based on your unique open enrollment period.

Our recommendation may include some or all the following approaches:

- **Introductory material –** Our mailers introduce your new Aetna plan and highlight any important changes retirees need to know. The materials may include clear, easy-to-understand comparison charts to help your retirees understand their group options (or just their new Aetna plan if it is the only option offered).

- **Informational meetings and/or conference calls/web conferences –** Retirees can gain a deeper understanding of plan benefits and get answers right from an Aetna representative. These sessions are highly recommended and are proven education solutions.

- **Enrollment Packets** – We design our enrollment packets with the retiree in mind making them easy to understand. They provide plan overviews, benefit summaries, how to find providers in our networks. These packets can be available at retiree meetings and/or on request to retirees who call us to learn more after reading one of our other mailers or sent proactively to your entire retiree population as part of a multi-element communications campaign.

- **Pre-enrollment call center support** – We staff our call centers with certified plan specialists trained specifically to address questions and assist Medicare beneficiaries in making a health plan choice that's best for their personal needs.

- **Post-enrollment** – Once a member has enrolled, they automatically receive CMS required Medicare Advantage (MA) membership materials including enrollment confirmation, ID cards, Schedule of Cost Sharing (SOC) and Evidence of Coverage (EOC) and Formulary notice. New members also receive a welcome kit called the Journey Handbook.

- **Aetna's Retiree Solutions Centers of Excellence** – To help provide members with a valuable service experience, we have developed Centers of Excellence for our customer service centers. We focus on empathy, caring, communication and listening to the caller. Further reinforcing the desired skills for empathy, we provide each member advocate with Senior Sensitivity training that shows the member advocate what it's like to live with the physical challenges that often come with aging, such as loss of hearing, vision and mobility. The training better equips our member advocates to provide the retiree with the sensitivity and attention they need. In addition, our member advocates participate in mandatory training classes, company-wide online training courses and customer-specific cultural training. Member advocates also receive training on specific topics, including eligibility and enrollment, benefit coverage claims (separate for MA and Prescription Drug Plan) and billing invoices. We built our customer service model to allow our member advocates to act as a single point of contact and they receive training to achieve first call resolution.

- **Newly Medicare eligible ("age-in") program** – We have an automated mail campaign for your retirees turning 65 and becoming Medicare eligible. The communications begin to mail *before* their 65th birthday. This program informs retirees about the advantages of the Aetna Medicare plan sponsored by you. It also encourages them to talk to an Aetna plan specialist who can help them understand how these plans work — easing their transition to the Medicare "world".

12. Do you agree to comply with all of the proposal assumptions and requirements as outlined in this SOQ? If not, specifically explain how your proposal deviates from this.

We have included exceptions and/or clarifications within the RFP submission where noted.

13. Do you agree to administer the requested benefits plan as described? If not, specifically identify any variations in plan designs.

The in-force Medicare Advantage plan design provided outlined multiple cost share options and ranges for certain benefits. The cost shares in the quoted Aetna Medicare Advantage plan fall within those options. We've included our Premier ESA Dental plan which duplicates the $1,000 maximum yearly benefit in the current plan for Preventive and Comprehensive benefits. The Aetna plan includes reimbursement benefits for eyewear and hearing aids which are in line with the benefits in the current plan.

14. Describe your enrollment process.

The Centers for Medicare & Medicaid Services (CMS) will allow a plan sponsor offering an Aetna Medicare Advantage (MA) plan or stand-alone Medicare prescription drug plan (PDP), to enroll eligible individuals in a group MA plan or PDP using an electronic enrollment process. Under this Optional Mechanism Enrollment process, the eligible Medicare beneficiary enrolls in a new Aetna Medicare plan by taking no action. This means the group electronic enrollment process ends the need for each eligible individual to complete and submit a paper enrollment application.

In addition, CMS requires that retirees receive advance written notice describing the plan details and disclosures. This written notice must contain all information needed for the individual to make informed decisions about their plan benefits. Anytime the Optional Mechanism Enrollment enrolls a retiree, the retiree has the option to decline the coverage.

The Group Electronic Enrollment process also allows plan sponsors to submit data feeds in multiple formats to our enrollment systems. Accommodating plan sponsors that elect to use this process requires that we receive at least 12 weeks advance written notice prior to the effective date of the plan. This helps make sure all customer specific set up and plan features are operational by the plan effective date.

CMS requires us to confirm that plan sponsors meet all CMS enrollment requirements before initiating the Optional Mechanism Enrollment process. The plan sponsor verifies that they meet the requirements by signing our Medicare Group Application.

We require a signed application before we can enroll any retiree in any of our group Medicare plans offered by the plan sponsor.

We accept the HIPAA 834 preferred and our 1700-byte data layout. We must review requests for custom data file layouts as they require lead time for programming and testing.

Our Retiree Solutions Center member advocates can accept enrollments and help retirees through the process. Our pre-enrollment member advocates specialize in Medicare beneficiary questions about eligibility, enrollment, networks and plan designs.

As your Aetna retiree plan members turn 65, they will enjoy the opportunities and face the changes associated with becoming a Medicare beneficiary. We ease this transition by communicating information about your Aetna Medicare Advantage (MA) plan that is relevant to your retirees' needs before their 65th birthday. Effective communications and education are critical in helping your retirees make the best decisions about their health plan and personal health.

Our direct mail campaign communicates the benefits of the Aetna Medicare plan sponsored by you and encourages them to contact an Aetna plan specialist to help ease their transition to the Medicare "world". The mail campaign includes multiple pieces co-branded with your logo. Your account team will work with you to define the age-in process that works best for Jefferson Parish's retirees.

After we enter an enrollment file into our eligibility system, the system creates an electronic file and sends it to CMS to verify Medicare Parts A and B eligibility for each person enrolled in a Medicare Advantage (MA) plan. CMS typically reviews the transaction files sent by Aetna daily and gives us an electronic confirmation or reply tape.

After completion of the verification process, we will send a Plan Acceptance Letter to the Medicare beneficiary with information about the proposed effective date of coverage. The Aetna Medicare Advantage plan ID card is issued within a few days of the Plan Acceptance Letter and mailed to the retiree's permanent home address. In general, a beneficiary can expect to get an ID card within seven to ten days after CMS verifies eligibility.

15. What is your administration charge as a percentage of premiums for JPG?

This is a fully insured quote; this is not applicable to our MAPD fully insured quote.

16. What is the JPG pooling level and estimated pooling charge for 2021?

This is a fully insured quote; this is not applicable to our MAPD fully insured quote.

17. What unique services or support does your organization provide that you believe sets you apart from your competition?

We understand the difficulty of offering quality retiree health benefits to your current and future retirees. At Aetna, we focus our retiree health business strategy on Jefferson Parish a broad range of programs and services to offer health, happiness and peace of mind to your retirees. Our Medicare Advantage (MA) plans can offer cost savings over traditional Medicare. They continually help to improve revenue management, increase efficiency and differentiate through high performance health care delivery.

We keep strengthening the value of our MA plans through four key areas:

- **A leader in care management:** We are proud of our investment in our robust care management initiatives. It's a retiree-focused approach that results in real savings. Retirees with complex medical needs, psychosocial issues and multiple health conditions — which often account for the greatest plan costs — get exceptional, coordinated care with fewer preventable hospital admissions.

- **Provider Collaboration:** Our Provider Collaboration Initiative improves care management, through regular communication with our value-based provider partners. This lets us work more effectively with the member to better understand their health needs. This lets us better manage care working with the member's doctors. It also helps the member take control of their long-term conditions and ideally, stay out of the hospital.

- **Medicare Star Ratings**: We have many programs designed to improve Star Ratings which, in turn, can result in bonuses from the Centers for Medicare & Medicaid Services (CMS) to sponsor MA plans — enhanced medical and care management support, improved self-service tools and increased member outreach.

  We keep achieving strong Medicare star quality ratings for our MA plans. For 2022 ratings, we achieved an overall average rating of 4.5 (out of 5) Stars across our MA plans and 99 percent of all our group MA members are in a 4 Star Rated plan or above. The industry average for the number of members in a 4.0 Star plan is 76 percent.

- **Risk adjusted revenue:** CMS changes premium payments to MA plans as the cost of covered services changes. That is why we maximize the data collection of important information from doctors for reporting to CMS. We continually confirm disease states with providers, as that has a positive impact on risk-adjusted revenue and effective care management.

18. Please provide results from the following surveys for 2020 or 2021:

- Member Satisfaction

The overall member satisfaction statistic for our Group Medicare Advantage (MA) plans is 96 percent.

- Provider Satisfaction

90 percent of providers report being satisfied overall with Aetna. 61 percent report being completely or very satisfied with Aetna.

- Benefits Manager Satisfaction

Our overall customer satisfaction score for Medicare Advantage is 96%.

19. For which services, and whom, do you outsource the following:

- Mental Health

We manage our behavioral health (BH) care management program internally, but we do leverage third parties for certain areas of expertise. Our plan enables members to access BH services directly from any provider that is eligible for Medicare and willing to accept the plan. Members never have to receive precertification or referral to access BH care.

In addition to our brick and mortar provider locations, Aetna engages MDLIVE, a leading provider of telehealth services, to provide members with greater access to behavioral health assistance. MDLIVE adds another option for those who prefer greater privacy and convenience for their behavioral health needs.

MDLIVE has over 1,000 providers specially trained in virtual and geriatric care. They are all Board-certified, licensed and credentialed in the state. Providers can help members with a broad range of behavioral health needs including addiction, depression/anxiety, stress management, relationship issues, grief and loss, LGBTQ support, eating disorders, couples therapy and more – all in the comfort and privacy of the member's home. MDLIVE offers both telephonic or video-based behavioral health visits that the member can access through the MDLIVE website or app.

- Laboratory

With our MAPD PPO with Extended Service Area plan, retirees are free to use any laboratory provider they choose.

- Vision

We do not outsource our visions benefits to any one provider.

For the annual routine eye exam, member may access care from any provider that is licensed, eligible for Medicare and willing to accept the plan. Members are never required to use Aetna contracted providers. If the plan provides for eyewear reimbursements, the member may get their glasses or contact lenses where they choose. Our plan provides the flexibility that retirees need.

We offer an eyewear allowance as a buy-up option you can add to your plan. In addition to an annual routine eye exam, Aetna offers variable eyewear allowance options over a 24-month period. Members can use the allowance at their discretion for the purchase of eyewear (contact lenses, glasses (frames and/or lenses) and upgrades — tinted lenses, progressive lenses, etc.).

To utilize the benefit, members pay for services at point-of-sale and submit to the plan for reimbursement. The submission must include the paid itemized receipt for services rendered. It is helpful if the member submits a reimbursement form as well. Members will receive reimbursement up to the allowance amount.

When the member receives services through EyeMed, they may receive additional discounts. In addition, EyeMed will apply the member's allowance at point-of-service and bill Aetna directly eliminating the need for member reimbursement.

Helping members to utilize benefits for eye exams and eyewear reimbursements helps to maintain their vision thus reducing risks for falls and depression.

- Prescription drug

We utilize our own pharmacy benefit management (PBM) services provider, CVS Caremark®. CVS Caremark has been providing PBM services since 1969. Today CVS Caremark serves more than 2,000 clients and their members across all 50 states, Puerto Rico and the U.S. Virgin Islands. Through mail, retail and specialty distribution channels, we administer programs for a diverse client base, including corporations, managed care organizations, insurance companies, government entities, unions, third-party administrators and other organizations.

CVS Health® has been working to serve Aetna members long before our organizations integrated as one. Aetna's relationship with CVS Health first began in 2010. As the PBM for Aetna, CVS Caremark handled claims administration and adjudication, network management, member services, mail order and Specialty Rx fulfillment and inventory. Together, our two companies focused on an integrated experience and simplified administration for both our customers and members.

Over the years, Aetna and CVS Health have worked hard together to create and deliver innovative solutions for our members and customers, including:

- Enhanced plan performance helping to reduce costs
- Digital tools to engage and enhance member experience
- Better adherence to positively impact health outcomes

For our customers like Jefferson Parish, this partnership means unified reporting, being equipped to make better decisions, streamlined plan administration with one account team, one implementation team and one eligibility file.

For our members, this means a more complete picture of their health, customized solutions for disease management and care management, targeted live care and ease of care including one ID card and one web portal with leading capabilities.

As a combined company, we're even better equipped to revolutionize health care.

- Network management

Aetna’s Credentialing unit manages the end-to-end credentialing process and ongoing license/sanction monitoring for all participating and nonparticipating providers. Our credentialing staff is responsible for making sure we verify all provider information and accurately record/maintain it to facilitate member access and minimize corporate risk. The credentialing staff is composed of analysts, consultants and managers whose scope and mission are to review, evaluate and validate provider data and support extensive research for state, federal and other regulatory compliance.

- Utilization management

We provide utilization management locally as part of a provider-centric model. The model establishes strong relationships between Aetna and providers. It also decreases provider abrasion. Most importantly, the model helps to improve member outcomes through proactive discharge planning activities.

Our nurses are located across the United States. They support our members in their neighborhoods where they live and seek care. A specialized team manages skilled nursing and rehabilitation stays following the provider-centric approach.

We also utilize subcontractors for some UM services, including: eviCore Healthcare in Bluffton, SC; EXL Service Holdings, Inc. in New York, NY; MyNEXUS in Brentwood, TN; and National Imagining Associates in Columbia, MD.

PDP Utilization Management

Following the Centers for Medicare & Medicaid Services (CMS) guidelines, we offer programs specifically designed to help manage the care of the Medicare population. We offer prospective, concurrent and retrospective drug utilization review (DUR) programs to help support correct prescribing, dispensing and medicine use in line with FDA guidelines, manufacturer labeling and peer-reviewed literature. Programs include the following:

Precertification

Precertification encourages the proper and cost-effective use of medicines by allowing coverage only when its intended use meets certain conditions. The precertification program is based on current medical findings, FDA approved manufacturer labeling information and cost considerations.

Quality Assurance

We also have point-of-sale, drug-to-drug and drug-to-age interaction edits where we require the pharmacist to document the intervention and outcomes for the promotion of patient safety.

Medication Therapy Management Programs

Aetna's Medicare Medication Therapy Management (MTM) program helps make sure that covered Part D drugs prescribed to targeted members are properly used to enhance therapeutic outcomes and to reduce the risk of adverse effects with drug therapy.

20. What are your weekday and weekend hours of telephone member services availability?

A beneficiary may contact Member Services for our MA plans between 8 AM and 9 PM ET Monday through Friday. Medicare Prescription Drug members can get their questions answered 24 hours a day, 365 days a year by a live agent.

After hours support
Aetna Voice Advantage, our self-service telephone system, will greet members who call into our Retiree Solutions Center after normal business hours (8 AM to 9 PM ET Monday through Friday). Aetna Voice Advantage makes it easy for retirees to check the status of their claims, confirm eligibility, request an ID card or obtain many kinds of information from Aetna, 24 hours a day, seven days a week.

Aetna Health, our secure member website, offers many online resources available 24/7, including benefits information, health education, health assessment tools and health care decision support. Recently, we began applying Aetna Health registration stickers to member ID cards with the goal of encouraging more members to register for Aetna Health. With the website, MA and Prescription Drug Plan (PDP) members have secure access any time. Members can:

- Check their claims status safely and securely and download for use in planning for health care expenses, tax reporting and record keeping
- Find a doctor, pharmacy, or facility
- View their personal health record
- Request a new ID card
- Add/change their primary care doctor
- View Explanation of Benefits statements
- View Evidence of Coverage
- Research treatments

- Get discount program information
- Download and print Aetna forms
- Contact Member Services through secure messaging in both English and Spanish
- Access alerts, e-mail messages and letters available through the Message Center
- View/download formulary
- Find easy-to-understand answers to questions about medicines, such as drug interactions, common side effects and what to do if they miss a dose
- View and track used benefits
- Order medicines through the home delivery mail-order drug website
- Order medicines not usually available at local pharmacies through the CVS Specialty® Pharmacy

Our secure member website also shows a member's progress toward:

- Meeting any required deductible
- Getting any maximum coverage plan contribution limit
- Meeting any maximum out-of-pocket coverage gap

Members who do not have access to the Internet may get the same information during standard business hours by calling the toll-free number on the back of their Aetna Medicare ID card.

Our secure member website helps members use their health plan and make their best health choices by giving access to:

- ***Our online provider search directory*** which includes details about providers and facilities as well as links to quality and patient safety information.

- ***Our pharmacy's website*** with interactive content to help manage both health and pharmacy costs. Members can also sign up for mail order drug and check their order status.

Members also have convenient, 24/7 access to our support via the online services on our secure member website. The website offers tools and information to help new and returning members make educated health care decisions and manage their benefits online.

21. For member services, what was the 2020 or 2021 telephone average speed of answer?

- Member Line

2021 – 23.3 seconds

- Provider Line

2021 – 71.4 seconds

- Combined Medical/Utilization Review Line

2021 Medical – 51.0 seconds

2021 Rx – 55.4 seconds

22. What is your Website address and what member information can be accessed from the Website?

Our mission is to build a customer experience that helps our members achieve their best health. Whether it's a member's medical, financial or overall wellbeing, Aetna Health, our secure member website, brings together the best of what we have to offer. Our comprehensive platform is a key part of transforming the digital member experience. Members have access to a personalized experience that supports them along their health care journey. Aetna Health gives members access to real-time information, tools and guidance to help members manage their health care and achieve their health ambitions. Members can use Aetna Health to:

- Connect to care
- Manage their plan
- Access tools for health and wellness

We created a member website that provides members with a personalized and proactive experience. It guides each member to the right information, resources and tools based on their needs — transforming how our members engage with their health care. Recently, we began applying Aetna Health registration stickers to member ID cards with the goal of encouraging more members to register for Aetna Health.

Connect to Care

One easy flow takes members from searching for a provider to comparing providers. This allows members to:

- Conduct a detailed provider search including in-network doctors and health care facilities based on the member's plan

- Identify providers offering telemedicine as part of the integrated search experience

- Access to quality ratings and patient reviews to aid in decision making

Managing benefits

Understanding benefits can be challenging. We connect members to the information they need to help them maximize and manage their benefits by allowing them to:

- View primary care physician (PCP) selections for themselves or for their covered dependents
- View coverage details for health care services such as office visits, tests, overnight hospital stays, same-day surgeries and urgent care
- See real-time benefit accumulators including their deductibles and out-of-pocket spending
- Access a digital ID card and share or download to Apple Wallet
- View up to two years of claims
- View claim details such as the amount paid by their plan and the amount that is the member's responsibility
- Download claims safely and securely
- Access an enhanced digital Explanation of Benefits (EOB). This provides members with a dynamic, personalized experience that includes information like amount billed, plan discount and total costs — all displayed in a colorful, interactive graph.
- Access pharmacy information
- Print out Aetna standard forms
- Track health care visits and history easily
- Contact member services through the secure messaging within our website

Accessing tools for health and wellness

We've packaged all our digital tools and resources for health and wellness together to make it easy for members to manage their health. The health and wellness section of our member website is a user-friendly touch point for all members regardless of their health status or goals.

Our health and wellness resources include:

- Recommended health actions
- Personal health record
- A suite of breast cancer resources for members and caregivers
- Health trackers

Our award-winning design uses visuals that capture members' interest and enthusiasm. We promote engagement by asking members their preferred method of communication and tailor our messages to reach members in a way that's most convenient for them.

Our digital tools make it easy for members to manage their health, but our platform is far from simple. There is a sophisticated technology operating in the background. Powered by our CareEngine®, the platform auto-populates claims data; continually analyzing it to identify opportunities to improve clinical outcomes. It displays the information to the member along with actions to help them achieve their health ambitions.

A personalized experience

We know living healthy means something different to everyone. It's why we provide members with a personalized and proactive experience. We personalize the member experience with:

- Proprietary algorithms that deliver a personalized experience based on demographics, health plan details, medical conditions and preferences

- Targeted messages based on claims, health events and more enable members to take meaningful action on their health goals and reduce health risks

- Personalized health and wellbeing editorial content relevant to each member

We never stop looking for innovative and meaningful ways to give our members access to engaging convenient and cost-effective health and wellness resources. Our member website supports our members' unique lifestyles and makes it easier for them to achieve their best health.

23. What is your 2021 target Per Member per Month (PMPM) medical cost for your network?

This is a fully insured quote; this question is not applicable.

24. For what procedures do you offer a Centers of Excellence program? Please provide a listing of locations utilized by procedure.

Aetna Institutes™ facilities are publicly recognized, high quality, high value health care facilities. Our goals are to:

- Recognize facilities with distinguished performance for health services that are critical to members.
- Engage consumers by providing them with information to help make informed choices about facilities with distinguished performance.
- Provide members access to high quality, cost-effective care.

Our program also offers travel and lodging reimbursement for patients and a companion who must travel over 100 miles to our facilities. However, travel and lodging excludes our infertility network.

Major components of Aetna Institutes

Institutes of Excellence™ (IOE)

This is our name for health care facilities that offer highly specialized clinical services to members with complex or rare conditions. Our nurse case managers nationally coordinate a member's clinical care for these cases. IOEs include:

- Transplant care
  - Heart
  - Lung
  - Heart/Lung
  - Simultaneous pancreas kidney (SPK)
  - Pancreas
  - Kidney
  - Liver
  - Intestine
  - Bone marrow/stem cell
  - CAR-T cell therapy*

- Pediatric congenital heart surgery

- Infertility

* In 2019, we added Chimeric Antigen Receptor T-cell therapy (CAR-T) to our IOE list. CAR T-cell therapy is cancer treatment that uses a patient's immune system cells, called T cells, after these cells are modified to better recognize and kill the patient's cancer. The T cells are engineered in a laboratory and then expanded to large numbers and infused back into the patient. National Contracting - Institutes Programs™ transplant program negotiates mutually acceptable rates with our IOE BMT/Stem Cell facilities providing these services.

Institutes of Quality® (IOQ)

This is our name for health care facilities that offer clinical services to members for prevalent health conditions. IOQs consisting of both ambulatory surgery centers and hospitals include:

- Bariatric surgery
  - Gastric bypass
  - Adjustable gastric band
  - Sleeve method

- Cardiac care
  - Cardiac medical interventions
  - Cardiac rhythm disorders
  - Cardiac surgery

- Orthopedic surgery
  - Total knee replacement
  - Total hip replacement
  - Spine

We identify IOE and IOQ facilities in our provider search, a key feature of the Aetna member website.

Please refer to the directory below for locations:

Transplant IOE Facility Listing
Institutes of Excellence hospitals NME national medical excellence program
https://aetna.highspot.com/items/5c7d32efa2e3a93d79edd050#1

Infertility IOE Facilities
Institutes of Excellence infertility services network clinics
https://aetna.highspot.com/items/5c7d32ea81171718c26f399c?lfrm=rhp.4

Pediatric Congenital Heart Surgery IOE Facilities
network hospitals listed by state
https://aetna.highspot.com/items/5c7d32eca2e3a93d8ded711f?lfrm=rhp.10#1

Bariatric IOQ Facilities Listing
Institutes of Quality for weight loss surgery
https://aetna.highspot.com/items/5c796b33f7794d186c507792?lfrm=rhp.2#1

Cardiac IOQ Facilities
Institutes of Quality specializing in heart procedures
https://aetna.highspot.com/items/5c796b3266bbaa4350d07a01?lfrm=rhp.10

Orthopedic IOQ Facility Listing
Institutes of Quality for joints and spine
https://aetna.highspot.com/items/5c796b31f7794d187a5055b9?lfrm=rhp.3

Behavioral Health IOQ Facilities
Institutes of Quality treating substance abuse and eating disorders
https://aetna.highspot.com/items/5c794504c714336959f523e1?lfrm=rhp.13

IOE and IOQ Map (updated September 2021)
https://aetna.highspot.com/items/5a1bda7caf772d017be68a99?lfrm=rhp.4#1

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25. A provider network is a critical part of the medical plan; therefore, include provider directory with your proposal. Also, provide a GEO Access report using a standard of two (2) providers within ten (10) miles.

Please see the *Accessibility Report – Jefferson Parish.pdf,* located in the Network Information section of our proposal responses.

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26. Is MD Anderson in Houston a network provider?

MD Anderson is non-par for Medicare products, which is not expected to change. MD Anderson requires a Letter of Agreement on file in order to see a Medicare member. The provider has set Letter of Agreement rates they will accept for Medicare members. This rate is updated yearly. The member would have to initiate care with MD Anderson and they would initiate the authorization and Letter of Agreement and then send to Aetna for review and execution.

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27. What disease management programs do you currently have in place?

Our care management programs help our members get the most out of retirement. We work with them to set realistic health goals and make programs and resources available to help them reach their goals. An essential part of this is our care management approach, which looks at members' whole health. By helping to ensure that our members have their physical, mental and social needs met, we help them achieve better health throughout retirement. Better health can lower medical costs and improve quality. This goes for every member no matter what their current state of health is.

Selecting and contacting members

We determine members for the program based on specific criteria, including medical and pharmacy claims, clinical notes, consumer information and hospital data.

Our nurse care managers initially reach out to members three separate times by telephone on different days of the week and different times (once in the morning and once in the evening). If we are unable to reach the member by telephone, we will send an Aetna Care Management Introduction letter by mail. This letter includes the name and direct telephone number for the member's assigned care manager. If the care manager does not get a call back from the member within 21 days, they close the case.

Once the member is engaged, the care manager generally works with the member by telephone for all care management programs. They may also work with some members face-to-face. The care manager will contact members on a weekly basis or more often if warranted. We are continuously working to increase the percentage of members who receive assistance in their homes and other community settings.

Provider engagement

Providers play a critical role in our member's lives and in our programs. Our care managers outreach to the member's physician to make them aware that their patient has enrolled in our Compassionate Care Program and attempt to work with the member's physician to coordinate the member's care and understand the plan of care.

Programs for High-Risk Members

An important part of our care management strategy is our whole-person, proactive approach that supports members' complex social and mental health needs, as well as their physical needs. Through the program we not only help members achieve their best health, even as their needs change, but we also work to lower medical costs and improve quality.

To keep things simple, every member gets their own care manager — a registered nurse or behavioral health expert who serves as their single point of contact, coordinating all the care and support for our members. The care manager uses motivational interviewing techniques to get to the heart of members' concerns, as well as their health and retirement goals. We use this information to create a custom plan of care for each member, which a complete team puts into action. The care manager and team can coordinate care using our care management system. This electronic system lets them see all the member's interactions with every one of our medical specialists, so there is a clear, complete picture of the member's health.

We outreach to our highest risk members to participate in our intensive care management programs. Our care management approach supports members using three integrated core program tracks:

<u>Readmission Avoidance Program (RAP)</u>
The Readmission Avoidance Program (RAP) supports members with a multidisciplinary team that consists of a care manager, social worker, pharmacist and dietician that work collaboratively to assist the member with their needs post-acute admission.

They also help members and their caregivers:

- Follow discharge instructions
- Reconcile and manage medication
- Understand what signs require medical attention right away
- Complete follow-up doctor's visits
- Understand their health conditions and how to manage them long-term
- Access other services and benefits, as needed

Most members who've recently been to the hospital have an average of five to six serious medical issues. That's why the pharmacist is one of the most important members of the team. Soon after discharge, the pharmacist looks at all the member's medicines and keeps in contact with the member's doctor to talk about any drug changes.

We determine members for the program based on specific criteria, including medical and pharmacy claims, clinical notes, consumer information and hospital data.

Our nurse care managers initially reach out to members three separate times by telephone on different days of the week and at different times (once in the morning and once in the evening). If we can't reach the member by telephone, we will send an Aetna Care Management Introduction letter by mail. This letter includes the name and direct telephone number for the member's assigned care manager. Once the member is engaged, the care manager generally works with the member by telephone for all care management programs. They may also work with some members face-to-face. We are continuously working to increase the percentage of members who receive assistance in their homes and other community settings**.**

Our Readmission Avoidance Program has been very successful. We currently have a 7 percent readmission rate, which is industry leading.

Complex Care Management (CCM)

The program is for members who are at risk of hospitalization in the near term. Addressing their complex needs takes collaboration with a nurse, medical director, pharmacist, social worker and behavioral health expert. Working together, the team finds underlying health issues and offers focused support. This includes helping members and their caregivers:

- Prioritize realistic goals
- Reconcile and manage medication
- Find the right community resources
- Coordinate care with the member's doctors

Because this program takes a whole-person approach, we focus on all the individual's complex conditions including mental illness such as depression, bipolar and schizophrenia, as well as their chronic and complex medical conditions. That's why we have a behavioral health expert on the medical team — to help make sure we address the member's emotional health as thoroughly as we address their physical needs. Other conditions we address include (but are not limited to):

- Congestive heart failure (CHF)
- Stroke
- Diabetes
- Chronic obstructive pulmonary disease (COPD)
- Long term pain
- Dementia
- Asthma

Our specific approach to CCM is as follows:

We identify the member for participation in the program and the member agrees to join the program.

An Aetna nurse or behavioral health specialist becomes the team lead for the case.

- The team lead reaches out to the member.
- The multidisciplinary team gets to work.

During the six months of the program: The team uses the Biopsychosocial Model ("BPS") to find all the physical, mental health and social causes playing a role in the member's health.

- The team addresses the "root causes" of health issues through intensive, well rounded support.
- The program may include face-to-face visits based on criteria.

End of six months: If the member meets their goals they will graduate from the program. If the member is nearing end of life, they can transition to the Aetna Compassionate Care program.

This program has had proven results as evidenced by a 36 percent reduction in avoidable inpatient admissions and a 20 percent reduction in emergency room utilization.[1]

1. Aetna 2017 Comorbid Condition Management study.

Aetna Compassionate Care Program (ACCP)

We offer programs and resources that support each of our members' needs. For members with advanced illness, we offer our nationally recognized Aetna Compassionate Care Program (ACCP) that offers more support to members and their families during difficult, sensitive times. ACCP provides support for members assessed as being nine to twelve months away from the end of life and referred to the program by our clinical staff.

Through our program, care managers help members make decisions related to end-of-life care and find some much-needed peace of mind. Support can include helping members, families and caregivers:

- Complete advance directives
- Manage pain and other distressing symptoms
- Clarify treatment goals
- Understand their options for care
- Access the care that is consistent with their values and preferences

ACCP provides support for members assessed as being nine to twelve months away from the end of life and referred to the program by our clinical staff. On average, we support members and their families for six months, but can offer longer support if it's beneficial. And if a member chooses hospice care, we continue to help them and their loved ones for an additional three months, helping ease them through a difficult period of grief. Our ability to be there for members — in some instances up to and through hospice care — has made a significant difference in quality of life. We've seen15 percent fewer inpatient admissions

[1]Baquet-Simpson, Alena, Spettell, Claire, Freeman, Allison N. et al "Aetna's Compassionate Care Program: Sustained Value for Our Members with Advanced Illness", Journal of Palliative Medicine, Vol 22, No 11. October 25, 2019

Programs for Moderate-Risk Members

Star Ratings Initiatives

Our focus is offering members programs that lead the industry, which is why we make improving our Medicare Star Ratings a top priority. This also leads to higher Centers for Medicare & Medicaid Services (CMS) value-based payments, which helps us to offer richer benefits and more competitive pricing. As a result, members can achieve better health without a lot of expense.

Our enrollment-weighted Star Ratings across our Medicare business is 4.5 Stars. Our 2022 Star Ratings place approximately 99 percent of our group members in 4 Star rated plans or higher. We plan to keep making major investments in Stars improvement to help ensure we can deliver the best in Medicare Advantage quality and value to the marketplace.

Two recent, major investments for improving Star Ratings are:

The creation of a “member profile” system for MA members, which automatically collects member information, giving us a complete picture of their ongoing care. This lets us easily find any gaps in care that might exist so that we can work with members and their doctors to close them.

The creation of a Healthy Outcomes Team, which offers advocacy and coaching to help members stick to their medication schedules. Consisting of about 80 nurses, pharmacists and social workers, we work with members who are not in our clinical programs but need help with their medication to manage good bone health or better manage uncontrolled blood pressure.

Aetna Advice

We can target messages that will resonate with your retirees, helping each member to choose better health-related behaviors and close gaps in care. With our connected data and predictive analytics, we coordinate actionable messaging and personalize it across multiple channels, including pharmacy, clinic, digital and care management staff. We ensure your retirees get the right message at the right time and in the right way. In one instance, we delivered over 300,000 personalized interactions, educating members on sites of care near them and what type of healthcare site is most appropriate for their unique needs. As a result, we saw a 23 percent decrease in avoidable ER visits — creating convenience for members and savings for plan sponsors.

Aetna Advice connects with members in multiple ways — via Aetna Health (our mobile app), email, direct mail, text and CVS retail channels. Recently, we began applying Aetna Health registration stickers to member ID cards with the goal of encouraging more members to register for Aetna Health.

Osteoporosis Management Program

We want to help members stay strong from the inside out. Our Osteoporosis Management Program helps address the loss of bone mineral density and helps reduce the likelihood of future breaks and fractures. Along with other services, this program helps members:

- Get testing for osteoporosis according to national guidelines
- Get the right prescription for treatment within six months of a fracture
- Review and resolve risks that could cause another fall

Through the program, we work with members who have had a recent fracture but don't appear to be on osteoporosis medicines, or who have not had a bone mineral density test in the last 24 months. A nurse care manager contacts the member and teaches them about osteoporosis and its risk causes. If it makes sense, the nurse will also help members schedule a bone mineral density test at a medical facility or potentially in-home. Our nurses can also make medicine recommendations for treating the condition.

28. Describe your current Wellness Program options and results, including what programs are provided to assist in healthy living.

Healthy Home Visits

Getting to the doctor isn't always easy, but it is important. That is why once a year we bring the doctor to our members, through our voluntary Healthy Home Visits program. This annual, in-home appointment with a nurse practitioner or doctor helps support the care a member gets from their regular doctors and includes a comprehensive exam. During the visit, the nurse or doctor reviews the member's health conditions (including diabetes and osteoporosis), medications, nutrition and need for help with day-to-day tasks. They will also:

- Review the member's overall physical health
- Study how safe their home environment is
- Decide if there are any quality/screening gaps
- Document any long-term conditions

After the visit, with the member's permission, we will share a summary of the visit and an overview of the findings with the member's primary care physician so they can make any adjustments needed to the member's care. The visiting nurse or doctor may also refer the member to one or more of our Care Management Programs to address a specific need or needs.

Fitness Benefit

We want members to stay active and make the most out of their retirement. That's why our Fitness Benefit Program encourages them to get out and exercise, with paid monthly gym memberships. We offer SilverSneakers® as a buy-up that you can purchase with the Medicare Advantage medical plan.

We contract with Tivity Health to offer the SilverSneakers fitness program. SilverSneakers offers features that can help members not only improve but sustain their health.

SilverSneakers offers a monthly membership at any one of thousands of participating fitness clubs and facilities nationwide. Members who don't live near one of these gyms, or just like to exercise at home, may order a SilverSneakers Steps At-Home Kit and select one of the following kits:

- General fitness
- Strength
- Walking
- Yoga

Each kit includes an instructional DVD and the equipment needed to take part. SilverSneakers also offers members hundreds of online workout videos available at SilverSneakers On-Demand™. Videos range from easy, low-impact exercises to cardio workouts.

Informed Health Line

When members have questions, we are here — day and night — to answer them. Members can call and talk directly with experienced nurses about thousands of health topics using our toll-free number. The nurses encourage members to make the best health care decisions and to talk with their doctors about any questions they have.

Annual Preventive Care Reminders

We know schedules can get hectic, so we send members annual reminders to help make sure they schedule important, routine appointments and tests. These include reminders for shots and colorectal cancer screenings, and for women's health concerns like breast and cervical cancers screenings. We can even work with members' doctors to arrange for some at-home, tests such as testing for colorectal cancer.

Healthwise® Knowledgebase

We believe helping members understand their care choices is a simple way to peace of mind. Our easy-to-use Healthwise® Knowledgebase system helps members make smart, confident decisions about treatments. For example, it can help members decide when it is okay to treat a health problem at home and when they should call a doctor. It also teaches them about treatments that may be available. The online tool is accessible in both English and Spanish, and offers information on 6,000 health topics, 600 medical tests and procedures, 500 support groups and 3,000 medicines.

Personal Health Record (PHR) with Multiple Online Health Trackers

We look out for members. That means staying on top of any changes to their health care needs. We offer an online system that gives our team a complete picture of each member's health, including doctor visits, lab work, diagnostic treatments and prescription drugs. It also includes information shared by the member, including over-the-counter medicines, family health history and allergies.
One of the key features of the system is the Vitals & Trackers page, which members can access. It displays the member's health information in easy-to-read graphs and tables, so members can check changes to health over time, including:

- Asthma peak flow*
- Blood glucose levels*
- Blood pressure*
- Creatinine
- Hemoglobin A1C
- HDL cholesterol
- activity*
- LDL cholesterol
- Total cholesterol
- Triglycerides
- Weight/BMI*
- Waist circumference
- Physical

Members may track their activity in five different groups:

- Heart and blood vessels
- Mind-body
- Sports
- Strength training and toning
- Other

*We offer you the chance to offer incentive/rewards to members to track this data.

Member Health Story

- Personalized communication to Medicare members designed to engage members to act on their overall health and partner with their doctor to get needed care.
- Booklet content personalized according to the member's eligibility and gap in care status for select measures.
- Select measures include: Breast cancer screening, Colon cancer screening, Comprehensive diabetes care, Statin therapy for people with cardiovascular disease, Controlling blood pressure
- Also includes health education relevant to all members like regular doctor appointments, vaccine schedule, body mass index, blood pressure, cholesterol, staying healthy, medication management.
- Bi-annual outreach in April and October

Other Important Programs

Provider Collaboration Initiative

One way to enhance members' health and peace of mind is to collaborate with their doctors directly. By working together through our Provider Collaboration Initiative, we find ways to enhance the quality and efficiency of care, while helping to improve outcomes for our members. We offer resources and incentives to help practices achieve our agreed upon quality goals.

There are three core parts of our provider collaboration relationships: Incentives that Encourage Quality and Efficiency, Care Coordination Support and Data Sharing.

Incentives that Encourage Quality and Efficiency

Working with practices, we figure out what quality goals we want to reach and create financial incentives for reaching them. These goals center on improving preventive care, following up with patients after an inpatient stay and watching long term conditions. Financed by Aetna, this payment approach encourages practices to achieve better outcomes, rather than deliver a high volume of services.

Care Coordination Support

It is important for the doctors we work with to have the support they need. As part of the program, we offer them a designated nurse care manager, who works with doctors and their staff to deliver invaluable support. This includes:

- Managing members' complex medical needs
- Assistance in reaching quality targets
- Managing population health by closing gaps and helping members access care
- Engaging members that are frequently hospitalized or visit the ER regularly

Ideally, a care manager will work as part of the doctor's team, which makes the assistance more effective. Care managers also share member information with doctors using our information systems. This includes timely data on prescriptions and inpatient stays. It is an approach that helps creates doctor-friendly collaboration in care management.

Data Sharing

One of the best ways to improve members' quality of care is to offer support to the doctors who care for them. This includes working with them to set quality goals and giving them reports with information about their practices. The reports also let doctors see their progress. These reports focus on clinical quality metrics, such as gaps in care for diabetics. They also have practice and member-level data, and we can provide them electronically on a daily, weekly, or monthly basis.

We also offer standardized reports for individual practices, down to the member-specific level for the 15 Healthcare Effectiveness Data and Information Set (HEDIS)-based Star metrics. These reports focus on specific areas of care, such as gaps in preventive screening or in the management of conditions, including diabetes and high blood pressure.

The nation's leading health policy journal, *Health Affairs*, published an extensively peer-reviewed study of our Medicare's Provider Collaboration results in Maine. It documented the improved quality and cost results seen in the three-year experience of the Aetna Maine Medicare and NovaHealth-InterMed Accountable Care model, which is an Innovation Profile.

29. Describe your pharmacy network.

For 2023, we offer three pharmacy network configurations with standard and preferred options at varying price points. Our Medicare pharmacy networks include major chains and independent retail pharmacies, long term care pharmacy providers, Indian Health Service (IHS), Tribal and Urban (I/T/U) pharmacies and home infusion pharmacy providers to meet the more specialized needs of our members.

We are proposing our P1 Preferred Network to Jefferson Parish.

- **P1 Preferred Network** – provides members with access to the more than 65,000 pharmacies in the S2 network. We do consider a subset of those pharmacies (approximately 23,500) preferred. This network has two sets of cost sharing:
  - **Preferred** – generally lower cost share on drugs when using preferred pharmacies
  - **Standard** – generally higher cost share on drugs when using standard pharmacies

Aetna also provides two additional pharmacy networks for our Medicare Advantage plans.

- P3 Preferred Network – Like the P1 network, plans with the P3 preferred network provides a lower price point by providing access to a smaller number of overall pharmacies. Members have access to more than 40,000 pharmacies which includes approximately 23,500 preferred pharmacies. This network has two sets of cost sharing:
  - **Preferred** – generally lower cost share on drugs when using preferred pharmacies
  - **Standard** – generally higher cost share on drugs when using standard pharmacies

S2 Standard Network – our standard network of over 65,000 pharmacies which includes all major chains. Through this extensive network, we make quality pharmaceutical services easily accessible to members at an affordable cost.

Current information about Aetna Medicare network pharmacies is available on our website at **aetnaretireeplans.com**.

We can offer better pricing in our preferred (P1 and P3) networks versus our standard (S2) network option**.** The preferred networks have more favorable contracts at the preferred pharmacies because the expectation is that the lower generic copays will steer more utilization into those pharmacies. We pass these lower costs through as lower member premiums.

30. How many Prescription Drug Lists (PDL's) does your company administer?

Aetna offers a wide range of CMS-compliant Part D formularies for our MAPD and PDP plans. Our group formularies provide members access to low-cost drug alternatives, allowing us to maximize coverage and reduce plan costs. Generally, drugs covered on the higher tiers have effective, lower-cost alternatives on lower tiers.

Our closed formularies cover subsets of Part D drugs prescribed for medically accepted uses for which a member meets medical necessity and follows plan rules. Closed formularies provide cost savings through a focus on generic drug utilization. When new drugs come to market classified as "Part D," we consider them for inclusion in the formulary. For 2023, Aetna offers five closed formularies, the Core, Core+, Classic, Classic+, Signature+.

The Core and Core+ formularies are the leanest drug list options with the lowest cost. The Core formulary includes generic drugs on all tier levels, even on tiers traditionally reserved for brand name drugs. The plan places high-cost generics on these tiers, requiring members to pay a higher share of the cost of these drugs, while providing savings to the plan sponsor. The Core+ formulary places generic drugs on separate generic tiers while placing brand drugs on separate brand tiers.

The Classic and Classic+ formularies offer mid-range coverage and exclude most multi-source brands. The Classic formulary includes generic drugs on all tier levels, even on tiers traditionally reserved for brand name drugs. The plan places high-cost generics on these tiers, requiring members to pay a higher share of the cost of these drugs, while providing savings to the plan sponsor. The Classic+ formulary places generic drugs on separate generic tiers while placing brand drugs on separate brand tiers.

The Signature+ formulary covers a broad range of drugs including multi-source brands. This formulary has strategic exclusions to help drive cost savings. The Signature+ formulary places generic drugs on separate generic tiers while placing brand drugs on separate brand tiers.

We will be proposing Jefferson Parish our open formulary, the Comprehensive+, which covers all Part D-eligible drugs prescribed for a medically accepted use. When new drugs come to market classified as "Part D," we generally add them to the open formulary after a brief period of review by our Pharmacy and Therapeutics

Committee. This committee determines which coverage tier we will include the drug in and which utilization and patient safety edits will apply to the drug.

31. If more than one PDL, what is the pricing differentials for each PDL and what is the impact on premiums and co-pays?

We are quoted our Comprehensive+ Formulary. If you would like us to price another one of our formularies, please request another formulary pricing.

32. Based on the top 100 drugs based on prescriptions filled, please identify which tier each drug falls under in your company's PDL.

Please see attached *Top100 - Tiering Comp+.*

33. Describe your mail order capabilities.

We provide mail order medications through our preferred mail order provider, CVS Caremark® Mail Service Pharmacy. Members can save time by ordering a three-month supply of their maintenance medications. Members will get their medications shipped securely and directly to their address. Standard shipping is always free.

CVS Caremark Mail Service Pharmacy services our members from two locations — Mt. Prospect, IL and Wilkes-Barre, PA.

34. What is your market share in your local market based on membership for 2019, 2020 and 2021?

We have included market share information from 2022, 2021, 2020, and 2019 below:

CVS Health Nationwide Medical Market Share (January 2022*)

Rank	% Share	Basis
#3	8%	Total book
#5	5%	In commercial fully insured products
#2	15%	In commercial self-funded products
#3	11%	In Medicare

Aetna Nationwide Medical Market Share (January 2020*)

Rank	% Share	Basis
#3	9%	Total book
#5	5%	In commercial fully insured products
#2	15%	In commercial self-funded products
#3	10%	In Medicare

* Based on the enrollment results of 372 national and local medical carriers, as of January 2020.

Aetna Nationwide Medical Market Share (July 2019*)

Rank	% Share	Basis
#3	9%	Total book
#5	5%	In commercial fully insured products
#2	15%	In commercial self-funded products
#3	10%	In Medicare

* Based on the enrollment results of 371 national and local medical carriers, as of July 2019.

35. What was your Louisiana profit/loss in 2020 and 2021? Please provide your 2020 or 2021 financial report.

We do not provide profit/loss by state, but we can provide profit/loss for our consolidated company – CVS Health Corporation:

- Net income (loss)
  ($ in Millions)
  2021 CVS Health Corporation $7,910
  2020 CVS Health Corporation $7,179

Please refer to our *2021 Financial Report.pdf* and *2020 Financial Report.pdf* attachments located in the Samples and Brochures section of our proposal response.

MEDICARE ADVANTAGE RATE PROPOSAL

Plan Sponsor Name:	**Jefferson Parish Government**
Policy Period Start Date:	**01/01/2023**
Policy Period End Date:	**12/31/2023**
Medical Plan:	**Medicare (P02) ESA PPO Plan**
Pharmacy Plan:	**RX $9/$20/$40/25%**

- Please refer to the Financial Conditions and Plan Design Exhibits for an outline of the level of benefits quoted, as well as the terms and conditions of this proposal.
- Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1 of each year and are subject to CMS contract approval.
- All rates are on a Per Member Per Month (PMPM) basis.
- These rates exclude commissions.

	Total MAPD Rate
Proposed	$0.00

Total Medicare Eligible Members	893

State	Medicare Eligible Members	Medical Rate
Alabama	2	$0.00
Arizona	2	$0.00
California	2	$0.00
Colorado	1	$0.00
Florida	3	$0.00
Louisiana	856	$0.00
Mississippi	13	$0.00
New York	1	$0.00
North Carolina	4	$0.00
Tennessee	4	$0.00
Texas	4	$0.00
Virginia	1	$0.00

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Medical Plan Highlights:	**Medicare (P02) ESA PPO Plan**
	In-Network Benefits match Out-Of-Network Benefits
Annual Deductible	$0
Primary Care Physician Visits	$5
Physician Specialist Visits	$20
Inpatient Hospital Care	$150 per day, days 1-5; $0 unlimited additional days
Outpatient Surgery	$100
Emergency Care; Worldwide	$65
Urgently Needed Care; Worldwide	$20
Skilled Nursing Facility	$0 per day, days 1-20; $25 per day, days 21-100
Medical Annual Max Out-of-Pocket	$2,500

Pharmacy Plan Highlights:	**Rx $9/$20/$40/25%**
Deductible	$0
Formulary	Comprehensive+
Network	P1
ICL Retail 30-Day Supply	T1: $10; T2: $20; T3: $40; T4: 25%
ICL Preferred Retail 30-Day Supply	T1: $9; T2: $20; T3: $40; T4: 25%
ICL Retail 90-Day Supply	T1: $30; T2: $60; T3: $120; T4: Limited to one-month supply
ICL Preferred Mail Order 90-Day Supply	T1: $18; T2: $40; T3: $80; T4: Limited to one-month supply
GAP Coverage	Gap Eliminated: Full Coverage in Gap - Generally the same cost sharing as Initial Coverage Phase; may be reduced when required by CMS
Catastrophic Coverage:	You pay the greater of 5% of the cost of the drug - or - $4.15 for a generic drug or a drug that is treated like a generic and $10.35 for all other drugs.
Rx Annual Max Out-of-Pocket	None

Not for Member Distribution. The benefits presented above are a high-level summary. Please review the Aetna MAPD Summary of Benefits for a more detailed list of covered services, member cost shares, services subject to deductibles and any plan limitations.

Jefferson Parish Government **January 1, 2023 through December 31, 2023**

Effective Date
The rates and benefit plan designs provided in this proposal are effective January 1, 2023 through December 31, 2023.

Definitions
For the purpose of this document: (1) "MA" means a group Medicare Advantage MA HMO and/or PPO plan without Medicare prescription drug coverage; (2) "MAPD" means a group MA HMO and/or PPO plan with Medicare prescription drug coverage; (3) "PDP" means a group standalone Medicare prescription drug plan; and (4) "ESA" means an MA PPO plan that uses a CMS-established waiver of service area requirements to offer coverage to eligible retirees/dependents who reside in an extended service area that does not offer a provider network that meets CMS network adequacy requirements.

The following conditions allow us to assess the potential financial impact and adjust premium rates, subject to applicable state and federal mandates:

- **Enrollment Assumptions** – The proposed rates assume member enrollment by plan type as outlined below:

Product	Enrolled Members
Medicare (P02) ESA PPO Plan with RX $9/$20/$40/25%	893

We reserve the right to rerate or restructure our rating if: a) the total enrollment varies by more than 10 percent from the enrollment assumption used in the enclosed rating or, b) if any site's enrolled membership expressed as a percent of total enrolled membership varies by more than +/- 10 percent from that assumed when rating the case. Aetna group retiree coverage does not extend to additional employer groups unless we are able to review supplemental census information and other underwriting information for appropriate financial review.

- **Full replacement** - This proposal assumes Aetna group retiree benefits will be a full replacement and the only plan for all current and future retirees from any source or other entity. If at any point in time during the period of the coverage, Aetna is not the full replacement plan, we reserve the right to revise, modify or terminate this proposal.

- **Legislative, Regulatory or Enforcement action** – Aetna reserves the right to rerate or restructure our rating for any legislative, regulatory or CMS changes or enforcement actions that cause a material change to taxes, fees, and assessments, required benefits, funding levels, or the manner and/or cost of providing Medicare Advantage with Part D Benefits.

- **Plan eligibility for MA and MAPD** -This proposal assumes all members are retired and enrolled in Medicare Part A and Part B. If you have retirees that are not eligible for premium free Part A they must be enrolled in an Aetna Medicare Part B only plan and separate rates will be provided to cover these members. Additionally, you represent that actively working employees and their dependents are not permitted to enroll in your group Medicare Advantage and/or Medicare Advantage with prescription drug plan(s) ("Plan(s)"), and that by offering the Plan(s) you intend to create and maintain a retiree plan that is separate from your active plan.

- **Employer contribution requirements** - This proposal assumes a minimum employer contribution level of 50% of the group premium for the Medical/Pharmacy plan. If the actual employer contribution differs from this assumed percentage, the medical and/or pharmacy rates and/or the plan offering are subject to revision.

- **Medicare Part D** - Aetna reserves the right to change the Medicare Part D premium, including the Medicare Part D component of the MAPD rate, or restructure the Part D plan design or formulary for the quoted plan year(s) if any changes are made to the laws, rules and/or regulations applicable to the Medicare Part D program.

  The premium developed in this proposal excludes any additional income-related Medicare Part D premium payments required of Medicare-eligible members in order for the member to be eligible for the Part D product.

  Aetna reserves the right to communicate with enrolled members regarding opportunities to reduce out of pocket prescription drug costs.

- **Medicare Part D Formulary** - The 2023 supplemental premium rate is limited to prescription drugs covered by our current formulary offering as of the date of this quote. Aetna reserves the right to adjust the 2023 premium if the formulary changes, per CMS review/approval of our 2023 formulary filing.

Jefferson Parish Government **January 1, 2023 through December 31, 2023**

- **Rate and benefit approval** - This proposal is subject to Centers for Medicare and Medicaid Services ("CMS") annual filing approval for the Medicare Advantage and Medicare prescription drug contracts, applications, and service areas for calendar year 2023. Filed benefits, including cost sharing amounts and premiums, are subject to regulatory approval(s), where applicable, and are effective January 1, 2023 through December 31, 2023.

- **Timely premium payments** - If a premium payment is not paid in full on or before the premium due date, a late payment charge of one and one-half percent of the total amount due per month may be added to the amount due, beginning with the premium due date. We also have the right to assess late premium payment and costs of collection of any unpaid premiums or fees, including reasonable attorney's fees and cost of suit.

- **End stage renal disease** - This section applies to Aetna's group MA, MAPD and PDPs (collectively, "Aetna Group Medicare Plans"). We assume that you don't enroll retirees and their dependents who are Medicare beneficiaries diagnosed with End Stage Renal Disease ("ESRD Beneficiaries") in the Aetna Group Medicare Plans during their 30-month coordination period, unless the ESRD beneficiaries maintain coverage under your commercial group health plan as the primary payer during their 30-month coordination period and the Aetna Group Medicare Plan is the secondary payer.

  We will only offer Aetna Group Medicare Plans to ESRD Beneficiaries in a manner that is consistent and complies with applicable laws, rules, and regulations, including, but not limited to, 42 C.F.R. § 422.50(a)(2) and other Medicare Advantage and Medicare Secondary Payer ("MSP") laws, rules and regulations and Centers for Medicare and Medicaid Services ("CMS") instructions ("MSP Requirements"). If an ESRD Beneficiary is eligible for or entitled to Medicare based on End Stage Renal Disease, federal law requires your commercial group health plan ("GHP") to be the primary payer for the first thirty months of the ESRD Beneficiary's Medicare eligibility or entitlement ("30-month coordination period"), regardless of the number of employees and regardless of whether the ESRD Beneficiary is a current employee or retiree. Therefore, you must confirm whether ESRD Beneficiaries are in their 30-month coordination period, and not enroll ESRD Beneficiaries in our Aetna Group Medicare Plan during their 30-month coordination period unless coverage under the GHP is maintained for such ESRD Beneficiaries for that period.

Aetna's understanding of the 21st Century Cures Act is that MSP Requirements continue to apply to ESRD Beneficiaries. This means that ESRD Beneficiaries will continue to have the option of enrolling in an Aetna Group Medicare Plan after they complete their 30-month coordination period, as permitted under MSP requirements. If CMS or any other federal agency with jurisdiction later indicates that MSP Requirements relating to ESRD Beneficiaries have changed as a result of the 21st Century Cures Act or any other applicable law, rule or regulation, Aetna reserves the right to revise or restructure the rates in this proposal.

- **Medical deductible credits** - This quote excludes medical deductible credits from our proposed medical plan.

- **Use of pharmacy data for medical management** - The enclosed medical rates assume that either, a) we are the pharmacy benefit administrator or PDP carrier or, b) we receive weekly pharmacy data feeds in an appropriate format from either you or your designated third party. The medical rates are subject to revision if either of these conditions does not occur.

- **Mail Order refill data transfer**- You must provide a Mail Order pharmacy open refill data file for electronic transfer of prescriptions to Aetna. The file must be received by October 1, 2022. Aetna does not charge a fee for incoming open refill files.

- **Additional products and services-** We will bill you for the cost of special services that are not included or assumed in the pricing. For example, you'll be subject to additional charges for customized communication materials. Costs will depend on the actual services performed and are determined at the time the service is requested.

Inaccurate or incomplete information – We're relying on information from you and your representatives in establishing the rates and terms of this proposal. If any of this information is inaccurate or incomplete and has a material impact on the cost of the programs, we reserve the right to adjust our rates and terms.

Proprietary and Confidential – This proposal contains trade secrets and commercial and financial information that Aetna deems proprietary and confidential and cannot be further released to any third party by Jefferson Parish Government without Aetna's prior written consent.

Aetna Intellectual Property

Under your Agreement with Aetna for the group Medicare Plans ("Agreement"), you may have access to certain of Aetna's Customer reporting systems. Aetna represents that it has either the ownership rights or the right to use all of the intellectual property used by Aetna in providing services under the Agreement ("Aetna IP"). Aetna will grant you, as the Customer, a nonexclusive, non-assignable, royalty free, limited right to use certain of the Aetna IP for the purposes described in the Agreement. You agree not to modify, create derivative product from, copy, duplicate, decompile, dissemble, reverse-engineer or otherwise attempt to perceive the source code from which any software component of the Aetna IP is compiled or interpreted. Nothing in the Agreement shall be deemed to grant any additional ownership rights in, or any right to assign, sublicense, sell, resell, lease, rent or otherwise transfer or convey, the Aetna IP to you.

Conclusion

We present this proposal on the condition that it will be accepted in its entirety. Furthermore, we've assumed that you'll continue to offer all other coverages, products, and services that you purchased previously. If there is a material change in this regard, we reserve the right to review and reprice this proposal. If you're interested in a subset of our proposal, then we will gladly review and reprice, if necessary. Before accepting the rates in this proposal, you must disclose any material deviation, current or expected, from these assumptions.

The most recent version of this document issued by Aetna to you, including any attachments to this document (collectively, "Financial Documents") are part of your agreement with Aetna to offer Medicare Advantage plans and/or standalone Medicare prescription drug plans ("Group Agreement"). In the event of a conflict between the terms of the Financial Documents and your Group Agreement and the documents incorporated into the Group Agreement, the order of priority shall be as described in your Group Agreement. Any riders, amendments, inserts and attachments shall have the same priority as the document to which they are attached.

Jefferson Parish Government **January 1, 2023 through December 31, 2023**

Broker commissions – The enclosed rates exclude broker commissions.

We honor 'Agent of Record' or 'Broker of Record' letters when an agent, broker, or consultant sells new business or takes over an Aetna case from another agent, broker, or consultant. Please have an appropriate representative from your organization sign the letter using your organization's letterhead. The change will become effective on the first day of the month after our payment unit receives the 'Agent of Record' or 'Broker of Record' letter unless another future date is designated in the letter.

Jefferson Parish Government **January 1, 2023 through December 31, 2023**

The following plan benefit information is being provided to notify Jefferson Parish Government of some important information related to Aetna's Medicare Advantage and Part D plans.

Medicare Advantage – Medical Plan Information

Network

CMS group enrollment waiver
CMS has established a waiver of network service area requirements ("Waiver") for some employer/union groups. Under this waiver, the employer/union may enroll their retirees in an MA HMO or PPO plan even if they reside in a service area that does not have access to network providers. We refer to these non-network service areas as "Extended Service Areas" (ESA).

In order to be eligible for the Waiver, at least 51 percent of your retirees and dependents must live in a service area that provides adequate access to network providers. Aetna will apply the CMS network requirements when determining if a county or service area meets adequate access requirements.

It is important to know that:

- Members in an ESA plan may not have access to the Aetna network of providers that meets CMS network adequacy requirements.
- Providers that are not contracted with Aetna are not required to accept the Aetna ESA PPO plan except for emergency and urgently needed care.

We will monitor the network adequacy throughout the year to confirm that standards are met. Our network teams will work to strengthen our provider networks to meet CMS network adequacy requirements to help avoid potential disruption to our members.

As of August 2022, 99% of your members reside in service areas that meet CMS network adequacy requirements. If the total percentage of members falls below 51 percent by the date of your Aetna MA PPO plan renewal, we cannot offer you our MA PPO ESA plan. However, we will work with you to evaluate other group health plan options that can be offered in these extended service areas to help reduce potential Member disruption.

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US Territories
Aetna offers Medicare Advantage PPO plans to retirees throughout the 50 states, Washington, DC, and the US Territories through use of a CMS service area waiver ("MA PPO ESA plans"). Please be advised that coverage under the MA PPO ESA plan in the US Territories is limited to medical coverage. Aetna MA PPO ESA plans do not offer fully insured Medicare prescription drug coverage in the US Territories. Therefore, if one of your MA PPO ESA plan members moves to a US Territory and Medicare prescription drug coverage is offered under that plan, the member will no longer be eligible for the plan. By mutual agreement, Aetna may offer a MA PPO ESA plan with medical coverage only for your members who reside in the US Territories, and we will discuss with you available pharmacy coverage options.

We are making you aware of these rules because of the potential impact to your account structure and eligibility files in this scenario. Please reach out to your Account Management Team for more information.

Part D Information

Prescription drug coverage
Our retiree pharmacy coverage consists of two components: basic Medicare Part D benefits and supplemental benefits.

- We offer Medicare Part D plan coverage pursuant to our contract with the CMS. We receive monthly payments from CMS for the Part D portion of your coverage.
- We offer supplemental coverage that wraps around the basic Medicare Part D benefits, allowing you to offer enhanced pharmacy benefits. We receive monthly premium payments from you and/or your retirees for the supplemental coverage. Depending on your plan design, supplemental coverage may also include benefits for non-Part D covered drugs.

We will report drug claims information to CMS, based on the source of the applicable coverage payment - Medicare Part D, plan sponsor or member.

Jefferson Parish Government **January 1, 2023 through December 31, 2023**

Aetna Mail Order and Specialty
Aetna's mail order benefits are filled by CVS Caremark® Mail Service Pharmacy. This mail order service supplies medications for drugs taken on a regular basis, sometimes referred to as maintenance drugs. Examples of maintenance drugs include medications used to treat chronic conditions such as arthritis, high cholesterol, asthma, or high blood pressure. CVS Caremark® Mail Service Pharmacy does not supply medications used for short-term illnesses, such as cold medications or antibiotics. Additionally, certain drugs that require special handling may not be available through CVS Caremark® Mail Service Pharmacy. These drugs are sometimes called specialty drugs and may require storage at controlled temperatures or other unique handling requirements which cannot be accommodated through a traditional mail order arrangement. Therefore, most specialty drugs are not available at the mail order benefit (cost share) and instead will pay at the retail benefit (cost share). Also, specialty drugs are generally limited to a 30-day fill, to reduce waste of these high-cost drugs.

Administration of the open formulary
Newly approved drugs won't be covered until they've undergone internal clinical review as well as external review by our Pharmacy and Therapeutics (P&T) Committee. Following the review, we will determine in which tier the drug will reside, include any applicable utilization management edits as approved by the P&T committee, and release the drug for coverage under open formulary plans.

The P1 Preferred Network plan option
This option provides a lower price point through the use of a pharmacy with preferred status. Members generally pay a lower cost share when utilizing pharmacies that are preferred. Members will also have access to standard pharmacies within the network; however, they will likely pay a higher cost share when receiving covered medications at standard pharmacies. To find a network pharmacy, members can visit our website: http://www.aetnaretireeplans.com.

Medicare Part D creditable coverage
If an applicant cannot demonstrate that he/she had prior creditable coverage, the applicant may incur late enrollment penalties, consistent with laws, rules, and regulations applicable to the Part D program.

Jefferson Parish Government **January 1, 2023 through December 31, 2023**

Premiums

- **Medicare Advantage – Premium Requirements** - The following requirements apply only if Aetna is offering a Medicare Advantage HMO or PPO Plan to your members, and you and your members are paying any portion of the premium for the Medicare Advantage benefit ("MA Premium"). CMS requires that we notify you of these requirements. You must comply with the following conditions with respect to any subsidization of MA Premium and any required MA Premium contribution by the member:

    1. You may subsidize different amounts of MA Premium for different classes of members and their dependents, provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried vs. hourly).

    2. MA Premium contribution levels cannot vary for members within a given class.

    3. Direct subsidy payments from CMS to Aetna must be passed through to reduce the amount of any required MA Premium payment by the member.

- **Premium and Low Income Subsidy ("LIS") Requirements and Late Enrollment Penalty ("LEP")** - Jefferson Parish Government will comply with the following conditions with respect to any subsidization of that portion of premiums paid by Jefferson Parish Government for the Medicare Prescription Drug benefit ("PD Premium") and any required PD Premium contribution by members enrolled in MAPDs or PDPs ("Members"):

    - Jefferson Parish Government may subsidize different amounts of PD Premium for different classes of Members and their dependents, provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried vs. hourly). Classes of Members and their dependents cannot be based on eligibility for the Low Income Subsidy ("LIS").

    - PD Premium contribution levels cannot vary for Members within a given class.

- Direct subsidy payments from CMS to Aetna must be passed through to reduce the amount of any required PD Premium payment by the Member ("Member Contribution") so the Member in no event shall be required to pay more than the sum of: a) the standard Medicare Part D premium, net of the direct subsidy payment from CMS, and b) one hundred percent (100%) for any supplemental coverage selected by the Member.

Jefferson Parish Government will comply with the following conditions with respect to any LIS payment received from CMS for any LIS-eligible Member:

- Any monthly LIS payment received from CMS for an LIS-eligible Member shall be used to reduce any Member Contribution. Any remainder may then be used to reduce the amount of the Jefferson Parish Government's PD Premium contribution. However, if the sum of the Member Contribution and Jefferson Parish Government's PD Premium is less than the LIS payment, any portion of the LIS payment will be returned to CMS by Aetna.

- If the LIS payment for any LIS-eligible Member is less than the Member Contribution required by such individual (including the Member Contribution for supplemental benefits, if any), Jefferson Parish Government shall communicate with the LIS-eligible Member about the cost of remaining enrolled in Jefferson Parish Government's Plan versus obtaining coverage as an individual under another Medicare Part D Prescription Drug plan.

- In the event that the LIS-eligible Member is due a refund of the LIS payment (i.e., there was no upfront reduction of the PD Premium by the LIS amount), such refund shall be completed by Aetna or Jefferson Parish Government, as applicable, within 45 days of the date Aetna receives the LIS payment for that Member from CMS.

Group Billed – If Aetna is billing and collecting the entire plan premium from Jefferson Parish Government and Jefferson Parish Government chooses to receive group list invoices, Aetna will apply LIS subsidy credits and LEP debits to the group invoice. Jefferson Parish Government must apply the LIS subsidy and collect the LEP consistent with applicable law.

Direct Billed - If Jefferson Parish Government chooses direct billing (i.e., Aetna directly bills and collects the entire plan premium from Members), Aetna will apply LIS to the Member invoice and will add LEP debits consistent with applicable law.

Jefferson Parish Government **January 1, 2023 through December 31, 2023**

Additional Retiree Programs

Helping your retirees obtain Medicaid coverage and access to community assistance programs

We're pleased to provide plan sponsors with a Medicaid outreach program through BeneLynk. This program provides continuous monitoring of social program eligibility and enrollment status to ensure appropriate access to benefits for which members are entitled.

This program includes:

- Community Programs to help members overcome food insecurity, transportation, social isolation, and lower the cost of utilities
- Initial Outreach and enrollment assistance with Medicaid or Medicare Savings Programs and the Low Income Subsidy
- Annual Recertification to maintain enrollment in these programs

We believe our Medicaid outreach program provides a valuable service to potentially eligible members by educating them about and screening for Medicaid programs. Medicaid eligibility may help reduce member out-of-pocket cost sharing and premiums. It can also help us reduce annual plan premium increases due to the additional payment we receive from CMS for these beneficiaries.

If your organization doesn't wish to participate and have your retirees contacted by BeneLynk, your organization may "opt-out" of our Medicaid outreach program. To do so, please contact your Aetna representative no later than October 1, 2022.

Please Note: If we don't receive your "opt-out" notification by October 1, 2022, your organization will be included in our Medicaid outreach program.

Jefferson Parish Government **January 1, 2023 through December 31, 2023**

Federal Information

Employer Reporting Requirements:
Under Internal Revenue Code (IRC) Section 6055 health insurance issuers, certain employers, government agencies and other entities that provide Minimum Essential Coverage (MEC) to individuals must report to the IRS information about the type and period of coverage and furnish related statements to covered individuals. This information is used by the IRS to administer the individual shared responsibility provision and by individuals to show compliance with the individual shared responsibility provision.

For Medicare plans (including Medicare Advantage), the reporting obligation under Section 6055 is on the Centers for Medicare and Medicaid Services (CMS) to the extent it applies. CMS will report the required information to the IRS about the type and period of coverage provided to each individual member enrolled in these plans and will furnish the required statements to subscribers.

IRC Section 6056 requires large employers (those having employed an average of 50 or more full-time employees during the preceding calendar year) to report to the IRS information about the health care coverage they have offered and also furnish applicable statements to employees. The purpose is to allow the IRS to enforce the employer responsibility provisions.

To satisfy the 6056 employer reporting requirements, you must file the required returns with the IRS by no later than February 28 of the year following coverage (if filing on paper) or March 31 (if filing electronically) and furnish a statement to all full-time employees by January 31st of the year following the calendar year to which the return relates (i.e., January 31, 2024 for the 2023 calendar year).

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., Aetna Life Insurance Company, SilverScript Insurance Company and/or their affiliates (Aetna). Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. Limitations, co-payments, and restrictions may apply. Benefits, pharmacy network, provider network, premium and/or co-payments/co-insurance may change on January 1 of each year.

Medicare Advantage/Medicare Part D Performance Guarantees

General Performance Guarantee Provisions – Fully Insured Premium

The Aetna companies of Aetna Health Inc. that currently provide health benefits administration and other services to our fully insured Medicare Advantage medical and Part D pharmacy group products include Aetna Health Inc., Aetna Health of California, Inc., Aetna Health of Illinois Inc., and/or Aetna Life Insurance Company. The performance guarantees shown in this document apply to fully insured Medicare Advantage plans with Medicare Part D pharmacy plans offered to Jefferson Parish Government that will be administered under a Group Agreement that will be issued to Jefferson Parish Government ("Group Agreement"). The Aetna company or companies named as parties to the Group Agreement will provide the services set forth in this document under the name of Aetna Health Inc. (hereinafter "Aetna").

Performance Objectives

Aetna believes that measuring the activities described below are important indicators of how well it services Jefferson Parish Government. Aetna is confident that the Plan Administration, Claim Administration, and Retiree Solutions Customer Services provided to Jefferson Parish Government will meet their high standards of performance. To reinforce Jefferson Parish Government's confidence in Aetna's ability to administer their program, Aetna is offering guarantees in the following areas:

Summary of Performance Standards

Performance Category	Minimum Standard	Penalty
Implementation		
▪ Implementation	Average evaluation score of 4.0 or higher	0.2%
▪ ID Card Production & Distribution	ID cards generated within 15 business days of confirmation by CMS	0.2%
Account Management		
▪ Overall Account Management Quarterly Meetings/Review Reports	Average evaluation score of 3.0 or higher	0.2%
Claim Administration		
▪ Medical Turnaround Time	90.0% of claims processed within 30 calendar days	0.1%
▪ Pharmacy Mail Order Dispensing Accuracy	99.95%	0.1%
Customer Services		
▪ Telephone Service Factor	80% within 30 seconds	0.1%
▪ Abandonment Rate	5.0%	0.1%
Total Percent of Supplemental Premium		**1.0%**

Medicare Advantage/Medicare Part D Performance Guarantees

Guarantee Period

The guarantees described herein will be effective for a period of 12 months and will run from **January 1, 2023 to December 31, 2023** (hereinafter "guarantee period").

The performance guarantees shown below will apply to the fully insured Medicare Advantage medical and Part D pharmacy plans administered under the Group Agreement.

For any performance guarantee that is unsatisfactory we will develop an improvement plan to achieve the stated performance guarantees.

If due to circumstances not within Aetna's reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of significant part of Aetna's Network Providers or entities with whom Aetna has contracted for services under this Group Agreement, or similar causes, the provision of medical or hospital benefits or other services provided under this Group Agreement is delayed or rendered impractical, Aetna shall not have any liability or obligation on account of such delay or failure to provide services, expect to refund the amount of unearned prepaid Premiums held by Aetna on the date such event occurs. Aetna is required only to make a good-faith effort to provide or arrange for the provision of services, considering the impact of the event.

Aggregate Maximum

In total, Aetna agrees to place **1.0%** of its applicable guarantee period customer paid premiums at risk through the Performance Guarantees outlined in this document. The guarantee period premiums will be calculated at the end of the guarantee period and will be based on the total number of retirees actually enrolled in the Medicare Advantage Medical plans throughout the guarantee period.

Medicare Advantage/Medicare Part D Performance Guarantees

Termination Provisions

Termination of the guarantee obligations shall become effective upon written notice by Aetna in the event of the occurrence of (i), (ii) or (iii) below:

(i) a material change in the plan initiated by Jefferson Parish Government or by legislative action that impacts the claim adjudication process, member service functions or network management.

(ii) failure of Jefferson Parish Government to meet its obligations to remit premiums as stipulated in the Group Agreement.

(iii) failure of Jefferson Parish Government to meet their administrative responsibilities (e.g., a submission of incorrect or incomplete eligibility information).

No guarantees shall apply for a guarantee period during which the Group Agreement is terminated by Jefferson Parish Government or by Aetna.

Refund Process

At the end of each guarantee period, Aetna will compile its Performance Guarantees results. If necessary, Aetna will provide a "lump sum" refund for any penalties incurred by Aetna.

Measurement Criteria

Except where otherwise stated below, Aetna's internal quality results for the Medicare book of business will be used to determine guarantee compliance.

Medicare Advantage/Medicare Part D Performance Guarantees

Implementation

Implementation Guarantee

Guarantee: Aetna developed and utilizes the implementation team concept to carefully coordinate all aspects of the implementation. An implementation manager will be assigned to assemble Jefferson Parish Government's implementation team and working with Jefferson Parish Government's team, will help determine the implementation priorities. The implementation manager will develop an implementation management plan that will outline the tasks to be accomplished and will also indicate mutually agreed upon target dates for their completion. As new information becomes available and priorities change, the plan will be updated. Jefferson Parish Government will be responsible for providing key information to Aetna by the mutually agreed upon target dates. The performance guarantee is contingent upon Jefferson Parish Government's required participation in reviewing Aetna's plan of benefits detail document.

Aetna is confident that Jefferson Parish Government will be pleased with our implementation team approach and therefore we are offering an implementation performance guarantee. This guarantee is effective for the implementation period in the first guarantee period. The implementation period commences at the initial implementation meeting and runs through the implementation sign-off.

Penalty and Measurement Criteria: Via timely responses to the Implementation Evaluation Tool, Jefferson Parish Government agrees to make Aetna aware of possible sources of dissatisfaction throughout the implementation period. Each question will be given a rating of 1 - 5 with 1 = lowest, 5 = highest. Results from the evaluation tool when will be used to facilitate a discussion between Jefferson Parish Government, the implementation manager and the Account Team regarding the results achieved. If, at the end of the implementation process, the final average score of the evaluations falls below 4.0, a mutually agreed upon penalty will apply, subject to a maximum penalty of **0.2%** of supplemental premium. The guarantee will be considered met if the survey is not returned.

ID Card Production and Distribution

Guarantee: Aetna guarantees that it will produce and mail ID cards to plan participants within 15 business days of receiving confirmation of eligibility from the Centers for Medicare & Medicaid Services (CMS).

Definition: For all ***complete, accurate and viable*** open enrollment eligibility data provided by Jefferson Parish Government, accepted by the system, and confirmed by CMS, Aetna agrees to produce and mail ID cards within 15 business days of receiving confirmation by Centers for Medicare & Medicaid Services (CMS-).

Medicare Advantage/Medicare Part D Performance Guarantees

Penalty and Measurement Criteria: Aetna will pay out an amount equal to **0.2%** of the guarantee period premiums if Aetna fails to produce and mail ID cards to Jefferson Parish Government members within 15 business days of receiving the eligibility confirmation file from CMS. Aetna's implementation team records will be used to determine whether ID cards were produced and mailed within the specified time frame.

Account Management

Overall Account Management Guarantee

Guarantee: Aetna will guarantee that the services (i.e., on-going financial, eligibility, drafting, and benefit administration and continued customer support) provided by the Field Office Account Management Staff during the guarantee period will be satisfactory to Jefferson Parish Government.

Penalty and Measurement Criteria: Via quarterly responses to the Account Management Evaluation Tool (sample attached), Jefferson Parish Government agrees to make Aetna aware of possible sources of dissatisfaction throughout the guarantee period. Jefferson Parish Government responses to the attached evaluation tool will evaluate account management services in the following categories: technical knowledge, accessibility of personnel, responsiveness of personnel, interpersonal skills, communication skills (written and oral) and overall assessment of the services provided to Jefferson Parish Government. Each category will be given a rating of 1 - 5 with 1 = lowest, 5 = highest. Aetna will tally the results from the report cards when received. The results of the first survey will be used to facilitate a discussion between Jefferson Parish Government and Aetna's Account Executive, regarding the results achieved and opportunities for improvement.

If the report cards are not completed and returned within one month of receipt, it will be assumed that the service provided to Jefferson Parish Government is satisfactory. If the score on the first report card is below an average rating of 3.0 and the service improves to an average of 3.0 for the second and subsequent surveys, no credit is due. Satisfactory service would equal a score of 3.0 and would be based on a total average of the survey questions with a rating scale of 1 to 5. Should the score from the first report card and the average of the remaining report cards fall below a 3.0 (meaning that service levels have not improved), Aetna will make a mutually agreed upon reduction in compensation, subject to a maximum reduction of **0.2%** of the guarantee period premiums.

Medicare Advantage/Medicare Part D Performance Guarantees

Claim Administration

Medical Turnaround Time

Guarantee: Aetna will guarantee that the claim turnaround time during the guarantee period will not exceed 30 calendar days for 90.0% of the processed claims on a cumulative basis each year.

Definition: We measure TAT from the claimant's viewpoint; that is, from the date the claim is received in the service center to the date that it is processed (paid or denied). TAT excludes those claims identified as rework.

Penalty and Measurement Criteria: If the cumulative year turnaround time (TAT) exceeds the day guarantee as stated above, Aetna will pay out an amount equal to 0.02% of the guarantee period premiums for each full day that Turnaround Time exceeds 30 calendar days for 90.0% of all claims. There will be a maximum reduction of **0.1%** of the guarantee period premiums. Guarantee results will be measured based on Aetna's book of business.

Pharmacy Mail Order Drug Accuracy

Guarantee: Aetna guarantees that at least 99.95% of all mail order prescriptions will be dispensed correctly for drug, strength, form, instructions, and patient.

Definition: For the respective guarantee period, total dispensing accuracy is measured as the number of prescriptions with no errors divided by the total number of prescriptions dispensed.

Penalty and Measurement Criteria: A penalty of .02% of the applicable guarantee period amount at risk will apply for each 1% that the actual percentage of all mail order prescription dispensing accuracy falls below the target of 99.95%. There will be a maximum penalty of **0.1%** of the applicable guarantee period premium at risk. Guarantee results will be measured based on Aetna's book of business.

Medicare Advantage/Medicare Part D Performance Guarantees

Member Services

Telephone Service Factor (TSF)

Guarantee: Aetna will guarantee that the TSF for the phone skill(s) providing your customer service are used and will not fall below **80.0%** of all calls responded to within **30** seconds.

Definition: TSF measures the speed at which calls are answered by Customer Service Advocates after being placed in queue by the auto attendant. This does not include the time the caller spent navigating through any auto attendant menus. TSF includes total calls (answered and abandoned) that are offered to Advocates. Interactive Voice Response (IVR) system calls are not included in the measurement of TSF. The TSF measure is a percentage of calls answered within 30 seconds. In the event there is an outage or when experiencing peak volumes, calls may be transferred to other Aetna call centers. This guarantee may not apply, and a penalty may not be paid if results are not achieved due to severe weather events which directly or indirectly impact performance during the guarantee period.

Penalty and Measurement Criteria: Aetna will pay out an amount of 0.02% of the guarantee period premium at risk for each full percentage point that the cumulative TSF falls below 80.0% for calls to be answered within 30 seconds. The maximum reduction will be **0.1%** of the guarantee period premiums. Guarantee results will be measured based on Aetna's Medicare book of business.

Abandonment Rate

Guarantee: Aetna will guarantee that the average rate of telephone abandonment for member services will not exceed 5.0%.

Definition: On an ongoing basis, Aetna measures telephone response time through monitoring equipment that produces a report on the average abandonment rate. The abandonment rate measures the total number of calls abandoned divided by the number of calls accepted into the unit.

Penalty and Measurement Criteria: Aetna will pay out an amount of 0.02% of the guarantee period premiums for each 1.0% that the average abandonment rate exceeds 5.0%. There will be a maximum reduction of **0.1%** of the guarantee period premiums. Guarantee results will be measured based on Aetna's Medicare book of business.

JEFFERSON PARISH GOVERNMENT
Aetna Medicare[SM] Plan (PPO)
Medicare (P02) ESA PPO Plan
Rx $9/$20/$40/25%

Benefits and Premiums are effective January 1, 2023 through December 31, 2023

SUMMARY OF BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Primary Care Physician (PCP): You have the option to choose a PCP. When we know who your provider is, we can better support your care.

Referrals: Your plan doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your doctor in order to see you.

Prior Authorizations: Your doctor will work with us to get approval before you receive certain services or drugs. Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

PLAN FEATURES	Network & out-of-network providers.
Monthly Premium	Please contact your former employer/union/trust for more information on your plan premium.
Annual Deductible	$0
This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.	
Annual Maximum Out-of-Pocket Amount	
Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay.	$2,500
It will apply to all medical expenses except Hearing Aid Reimbursement , Vision Reimbursement , Dental Coverage and Medicare prescription drug coverage that may be available on your plan.	

HOSPITAL CARE*	This is what you pay for network & out-of-network providers.
Inpatient Hospital Care	$150 per day, days 1-5; $0 unlimited additional days
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Observation Stay	Your cost share for Observation Care is based upon the services you receive
Frequency:	per stay
Outpatient Services & Surgery	$100
Ambulatory Surgery Center	$75
PHYSICIAN SERVICES	**This is what you pay for network & out-of-network providers.**
Primary Care Physician Visits	$5
Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.	
Physician Specialist Visits	$20
PREVENTIVE CARE	**This is what you pay for network & out-of-network providers.**
Medicare-covered Preventive Services	$0

- Abdominal aortic aneurysm screenings
- Alcohol misuse screenings and counseling
- Annual Well Visit - One exam every 12 months.
- Bone mass measurements
- Breast exams
- Breast cancer screening: mammogram - one baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.
- Cardiovascular behavior therapy
- Cardiovascular disease screenings
- Cervical and vaginal cancer screenings (Pap) - one routine GYN visit and pap smear every 24 months.
- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- Depression screenings
- Diabetes screenings

• HBV infection screening • Hepatitis C screening tests • HIV screenings • Lung cancer screenings and counseling • Medicare Diabetes Prevention Program - 12 months of core session for program eligible members with an indication of pre-diabetes. • Nutrition therapy services • Obesity behavior therapy • Pelvic Exams - one routine GYN visit and pap smear every 24 months. • Prolonged Preventive Services - prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service • Prostate cancer screenings (PSA) - for all male patients aged 50 and older (coverage begins the day after 50th birthday) • Sexually transmitted infections screenings and counseling • Tobacco use cessation counseling • Welcome to Medicare preventive visit	
Immunizations • Flu • Hepatitis B • Pneumococcal	$0
Additional Medicare Preventive Services • Barium enema - one exam every 12 months. • Diabetes self-management training (DSMT) • Digital rectal exam (DRE) • EKG following welcome exam • Glaucoma screening	$0
EMERGENCY AND URGENT MEDICAL CARE	**This is what you pay for network & out-of-network providers.**
Emergency Care; Worldwide (waived if admitted)	$65
Urgently Needed Care; Worldwide	$20

DIAGNOSTIC PROCEDURES*	This is what you pay for network & out-of-network providers.
Diagnostic Radiology CT scans	$20
Diagnostic Radiology Other than CT scans	$20
Lab Services	$0
Diagnostic testing & procedures	$20
Outpatient X-rays	$20
HEARING SERVICES	**This is what you pay for network & out-of-network providers.**
Routine Hearing Screening We cover one every twelve months	$0
Medicare Covered Hearing Examination	$20
Hearing Aid Reimbursement Applies to in or out of network	$1,000 per ear every 12 months
Hearing Aid Benefit Vendor:	N/A Not Covered
DENTAL SERVICES	**This is what you pay for network & out-of-network providers.**
Dental - Premier ESA **Coverage includes cleanings, checkups, X-rays and comprehensive services** **Annual Benefit Maximum - $1,000 each year**	
Preventive dental services	$0 dental deductible 0% coinsurance for each dental service
Comprehensive dental services	$0 dental deductible 50% coinsurance for each dental service
Medicare Covered Dental* Non-routine care covered by Medicare.	$20

VISION SERVICES	This is what you pay for network & out-of-network providers.
Routine Eye Exams One annual exam every 12 months.	$15
Diabetic Eye Exams	$0
Medicare Covered Eye Exam	$20
Vision Eyewear Reimbursement Applies to in or out of network	$300 once every 12 months
MENTAL HEALTH SERVICES*	**This is what you pay for network & out-of-network providers.**
Inpatient Mental Health Care	$150 per day, days 1-5; $0 unlimited additional days
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Mental Health Care Individual visit	$20
Partial Hospitalization	$20
Inpatient Substance Abuse	$150 per day, days 1-5; $0 unlimited additional days
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Substance Abuse Individual visit	$20
SKILLED NURSING SERVICES*	**This is what you pay for network & out-of-network providers.**
Skilled Nursing Facility (SNF) Care	$0 per day, days 1-20; $25 per day, days 21-100
Limited to 100 days per Medicare Benefit Period. The member cost sharing applies to covered benefits incurred during a member's inpatient stay. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.	
PHYSICAL THERAPY SERVICES*	**This is what you pay for network & out-of-network providers.**
Outpatient Rehabilitation Services (Speech, physical, and occupational therapy)	$20

AMBULANCE SERVICES	This is what you pay for network & out-of-network providers.
Ambulance Services	$50

Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.

TRANSPORTATION SERVICES	This is what you pay for network & out-of-network providers.
Transportation (non-emergency)	24 trips with 60 miles allowed per trip

MEDICARE PART B PRESCRIPTION DRUGS*	This is what you pay for network & out-of-network providers.
Medicare Part B Prescription Drugs	20%

MEDICARE PART D PRESCRIPTION DRUGS	This is what you pay for network & out-of-network providers.

Part D drugs are covered. See PHARMACY - PRESCRIPTION DRUG BENEFITS section below for your plan benefits at each part D stage, including cost share and other important pharmacy benefit information.

ADDITIONAL PROGRAMS AND SERVICES	This is what you pay for network & out-of-network providers.
Allergy Shots	$0
Allergy Testing	$0
Blood	$0
All components of blood are covered beginning with the first pint.	
Cardiac Rehabilitation Services	$20
Chiropractic Services*	$20
Medicare covered benefits only.	
Diabetic Supplies*	$0
Includes supplies to monitor your blood glucose from LifeScan.	
Durable Medical Equipment/ Prosthetic Devices*	10%
Home Health Agency Care*	$0
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.
Medical Supplies*	10%
Medicare Covered Acupuncture	$20
Outpatient Dialysis Treatments*	$20
Podiatry Services	$20
Medicare covered benefits only.	
Pulmonary Rehabilitation Services	$20
Radiation Therapy*	$20

ADDITIONAL PROGRAMS (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network & out-of-network providers.
Fitness Benefit	SilverSneakers
Meals	$0
Covered up to 14 meals following an inpatient stay.	
Over-the-counter (OTC) items	$0
OTC Kit	N/A
Allowance	$50
Frequency	quarterly
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Resources For Living®	Covered
For help locating resources for every day needs.	
Teladoc™	$0
Telemedicine services with a Teladoc™ provider. State mandates may apply.	
Telehealth	Covered
Telemedicine Services. Member cost share will apply based on services rendered.	
Telehealth PCP	$0
Telehealth Specialist	$20
Telehealth Other Health care Providers	$20
Telehealth Individual Mental Health	$0
Telehealth Behavioral Health	$0
Vendor: MD Live	
Telehealth Group Mental Health	$0
Telehealth Individual Psychiatric Services	$0
Telehealth Group Psychiatric Services	$0
Telehealth Urgent care	$0

ADDITIONAL SERVICES (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network & out-of-network providers.
Routine Physical Exams	$0
One exam per calendar year	

Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

See next page for Pharmacy-Prescription Drug Benefits.

PHARMACY - PRESCRIPTION DRUG BENEFITS

Calendar-Year deductible for Prescription drugs $0

Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible.

Pharmacy Network P1

Your Medicare Part D plan uses the network above. To find a network pharmacy, you can visit our website (http://www.aetnaretireeplans.com.)

Formulary (Drug List) Comprehensive+

Initial Coverage Limit (ICL) $4,660

The Initial Coverage Limit includes the plan deductible, if applicable. This is your cost sharing until covered Medicare prescription drug expenses reach the Initial Coverage Limit (and after the deductible is satisfied, if your plan has a deductible):

4 Tier Plan	30-day Supply through Retail		90-day Supply through Retail or Mail		
	Preferred	**Standard**	**Preferred Retail**	**Preferred Mail**	**Standard Retail or Mail**
Tier 1 - Generic Generic Drugs	$9	$10	$18	$18	$30
Tier 2 - Preferred Brand Preferred Brand Drugs	$20	$20	$40	$40	$60
Tier 3 - Non-Preferred Brand Non-Preferred Brand Drugs	$40	$40	$80	$80	$120
Tier 4 - Specialty Includes high-cost/unique generic and brand drugs	25%	25%	Limited to one-month supply	Limited to one-month supply	Limited to one-month supply

If you reside in a long-term care facility, your cost share is the same as a 30 day supply at a retail

pharmacy and you may receive up to a 31 day supply.

Coverage Gap

The Coverage Gap starts once covered Medicare prescription drug expenses have reached the Initial Coverage Limit. Your cost-sharing for covered Part D drugs after the Initial Coverage Limit and until you reach $7,400 in prescription drug expenses is indicated below.

Your former employer/union/trust provides additional coverage during the Coverage Gap stage for covered drugs. This means that you will generally continue to pay the same amount for covered drugs throughout the Coverage Gap stage of the plan as you paid in the Initial Coverage stage. Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

Catastrophic Coverage:	You pay the greater of 5% of the cost of the drug - or - $4.15 for a generic drug or a drug that is treated like a generic and $10.35 for all other drugs.

Catastrophic Coverage benefits start once $7,400 in true out-of-pocket costs is incurred.

Requirements:	
Precertification	Applies
Step-Therapy	Applies

Non-Part D Supplemental Benefit

- Not Covered

Medical Disclaimers

For more information about Aetna plans, go to **www.AetnaRetireePlans.com** or call Member

Services at toll-free at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

The provider network may change at any time. You will receive notice when necessary.

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

In case of emergency, you should call 911 or the local emergency hotline. Or you should go directly to an emergency care facility.

The complete list of services can be found in the Evidence of Coverage (EOC). You can request a copy of the EOC by contacting Member Services at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your Evidence of Coverage
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

You may pay more for out-of-network services. Prior approval from Aetna is required for some network services. For services from a non-network provider, prior approval from Aetna is recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

Out-of-network/non-contracted providers are under no obligation to treat Aetna members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Aetna will pay any non contracted provider (that is eligible for Medicare payment and is willing to accept the Aetna Medicare Plan) the same as they would receive under Original Medicare for Medicare covered services under the plan.

Pharmacy Disclaimers

Aetna's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offered as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna based on our contract with CMS. We receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

Aetna's pharmacy network includes limited lower-cost, preferred pharmacies in Suburban Arizona, Suburban Illinois, Urban Kansas, Rural Michigan, Urban Michigan, Urban Missouri, Urban Pennsylvania, Suburban Utah, Suburban West Virginia, Suburban Wyoming. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call 1-866-241-0357 (TTY: 711) or consult the online pharmacy directory at http://www.aetnaretireeplans.com.

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances as defined in the EOC. In these situations, you are limited to a 30 day supply.

Pharmacy clinical programs such as precertification, step therapy and quantity limits may apply to your prescription drug coverage.

Members who get "extra help" don't need to fill prescriptions at preferred network pharmacies to get Low Income Subsidy (LIS) copays.

Specialty pharmacies fill high-cost specialty drugs that require special handling. Although specialty pharmacies may deliver covered medicines through the mail, they are not considered "mail-order pharmacies." Therefore, most specialty drugs are not available at the mail-order cost share.

The typical number of business days after the mail order pharmacy receives an order to receive your shipment is up to 10 days. Enrollees have the option to sign up for automated mail order delivery. If your mail order drugs do not arrive within the estimated time frame, please contact us toll-free at 1-866-241-0357, 24 hours a day, 7 days a week. TTY users call 711.

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. The amount you pay and the amount discounted by the manufacturer count toward your out-

of-pocket costs as if you had paid them and moves you through the coverage gap.

Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

There are three general rules about drugs that Medicare drug plans will not cover under Part D. This plan cannot:

- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.
- Generally cover drugs prescribed for "off label" use, (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

Additionally, by law, the following categories of drugs are not normally covered by a Medicare prescription drug plan unless we offer enhanced drug coverage for which additional premium may be charged. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs". These drugs include:

- Drugs used for the treatment of weight loss, weight gain or anorexia
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs that the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs used to promote fertility
- Drugs used to relieve the symptoms of cough and colds
- Non-prescription drugs, also called over-the-counter (OTC) drugs
- Drugs when used for the treatment of sexual or erectile dysfunction

Plan Disclaimers

Aetna Medicare is a HMO and PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., Aetna Life Insurance Company and/or their affiliates (Aetna). Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The

availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

The formulary, provider and/or pharmacy network may change at any time. You will receive notice when necessary.

Resources For Living is the brand name used for products and services offered through the Aetna group of subsidiary companies.

If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

You can read the *Medicare & You 2023* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-267-2637 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-267-2637 (TTY: 711). Traditional Chinese: 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-888-267-2637 (TTY: 711).

You can also visit our website at http://www.aetnaretireeplans.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

*****This is the end of this plan benefit summary*****

Y0001_GRP_1099_3732a_2021_M

A Report on the Accessibility Analysis of the

Aetna Medicare PPO - 2023

Jefferson Parish

August 7, 2022

Contents

Report Contents

Access Summary By City

August 7, 2022

Access Analysis
_9 In Network All Standard 2 - Open

Employee Group
In Network EEs (Aetna Medicare Plan (PPO) - 2023)

Provider Group
PCPs - Open
All Specialists - Open
Hospitals

[1] Provider counts represent:
#: Provider access points
P: Unique providers
L: Unique provider locations

All Employees

Employee		Provider	Access Results			Counts[1]			Average Distance	
Group	#	Group / Access Standard		#	%	#	P	L	1	2
In Network EEs	832	PCPs - Open / 2 in 10 miles	With	828	99.5	531,883	208,522	79,870	1.0	1.1
		PCPs - Open / 2 in 10 miles	W/o	4	0.5				10.3	10.7
		All Specialists - Open / 2 in 10 miles	With	829	99.6	3,038,862	814,625	194,414	0.9	1.0
		All Specialists - Open / 2 in 10 miles	W/o	3	0.4				10.4	10.6
		Hospitals / 2 in 10 miles	With	774	93.0	6,497	4,189	5,692	2.5	3.0
		Hospitals / 2 in 10 miles	W/o	58	7.0				8.4	13.2

Key Geographic Areas

City	Employee	Provider	Access Results			Counts[1]	Average Distance	
	#	Group / Access Standard		#	%	#	1	2
Metairie, LA	180	PCPs - Open / 2 in 10 miles	With	180	100.0	201	0.5	0.6
		PCPs - Open / 2 in 10 miles	W/o	0	0.0		--	--
		All Specialists - Open / 2 in 10 miles	With	180	100.0	985	0.4	0.5
		All Specialists - Open / 2 in 10 miles	W/o	0	0.0		--	--
		Hospitals / 2 in 10 miles	With	180	100.0	2	1.8	2.2
		Hospitals / 2 in 10 miles	W/o	0	0.0		--	--
Marrero, LA	151	PCPs - Open / 2 in 10 miles	With	151	100.0	110	1.0	1.1
		PCPs - Open / 2 in 10 miles	W/o	0	0.0		--	--
		All Specialists - Open / 2 in 10 miles	With	151	100.0	505	1.1	1.1
		All Specialists - Open / 2 in 10 miles	W/o	0	0.0		--	--
		Hospitals / 2 in 10 miles	With	151	100.0	3	2.1	2.2
		Hospitals / 2 in 10 miles	W/o	0	0.0		--	--
New Orleans, LA	107	PCPs - Open / 2 in 10 miles	With	107	100.0	708	0.8	0.9
		PCPs - Open / 2 in 10 miles	W/o	0	0.0		--	--
		All Specialists - Open / 2 in 10 miles	With	107	100.0	3,225	0.4	0.5
		All Specialists - Open / 2 in 10 miles	W/o	0	0.0		--	--
		Hospitals / 2 in 10 miles	With	107	100.0	9	2.4	2.7
		Hospitals / 2 in 10 miles	W/o	0	0.0		--	--
Kenner, LA	66	PCPs - Open / 2 in 10 miles	With	66	100.0	72	0.5	0.5
		PCPs - Open / 2 in 10 miles	W/o	0	0.0		--	--
		All Specialists - Open / 2 in 10 miles	With	66	100.0	332	0.4	0.5
		All Specialists - Open / 2 in 10 miles	W/o	0	0.0		--	--
		Hospitals / 2 in 10 miles	With	66	100.0	0	4.2	4.5
		Hospitals / 2 in 10 miles	W/o	0	0.0		--	--
Gretna, LA	59	PCPs - Open / 2 in 10 miles	With	59	100.0	46	0.4	0.4
		PCPs - Open / 2 in 10 miles	W/o	0	0.0		--	--
		All Specialists - Open / 2 in 10 miles	With	59	100.0	168	0.3	0.3
		All Specialists - Open / 2 in 10 miles	W/o	0	0.0		--	--
		Hospitals / 2 in 10 miles	With	59	100.0	1	2.1	3.3
		Hospitals / 2 in 10 miles	W/o	0	0.0		--	--

Access Detail By Zip Code

August 7, 2022

Access Analysis
- _9 In Network All Standard 2 - Open

Employee / Provider Groups
- In Network EEs (Aetna Medicare Plan (PPO) - 2023)
  - PCPs - Open
  - All Specialists - Open
  - Hospitals

All Employees												
State Name	City	Zip Code	Employee #	Provider		Counts	With Access		Without Access		Average Distance	
				Group	Standard	#	#	%	#	%	1	2
California	Alpine	91901	1	PCPs - Open	2 in 10 miles	3	1	100.0	0	0.0	1.3	1.6
				All Specialists - Open	2 in 10 miles	51	1	100.0	0	0.0	0.7	0.7
				Hospitals	2 in 10 miles	0	0	0.0	1	100.0	18.1	20.9
Louisiana	Abita Springs	70420	2	PCPs - Open	2 in 10 miles	0	2	100.0	0	0.0	3.4	3.4
				All Specialists - Open	2 in 10 miles	0	2	100.0	0	0.0	2.6	3.0
				Hospitals	2 in 10 miles	0	2	100.0	0	0.0	3.4	5.2
	Addis	70710	1	PCPs - Open	2 in 10 miles	0	1	100.0	0	0.0	2.6	2.9
				All Specialists - Open	2 in 10 miles	0	1	100.0	0	0.0	2.3	2.3
				Hospitals	2 in 10 miles	0	1	100.0	0	0.0	9.3	9.9
	Barataria	70036	1	PCPs - Open	2 in 10 miles	0	1	100.0	0	0.0	2.2	2.2
				All Specialists - Open	2 in 10 miles	0	1	100.0	0	0.0	2.2	2.2
				Hospitals	2 in 10 miles	0	0	0.0	1	100.0	11.9	12.6
	Baton Rouge	70810	2	PCPs - Open	2 in 10 miles	25	2	100.0	0	0.0	0.7	0.7
				All Specialists - Open	2 in 10 miles	331	2	100.0	0	0.0	0.6	0.6
				Hospitals	2 in 10 miles	2	2	100.0	0	0.0	1.1	1.2
		70817	1	PCPs - Open	2 in 10 miles	13	1	100.0	0	0.0	1.0	1.9
				All Specialists - Open	2 in 10 miles	218	1	100.0	0	0.0	1.0	1.0
				Hospitals	2 in 10 miles	2	1	100.0	0	0.0	2.0	2.1
	Bush	70431	12	PCPs - Open	2 in 10 miles	0	8	66.7	4	33.3	9.1	9.4
				All Specialists - Open	2 in 10 miles	0	9	75.0	3	25.0	8.8	9.2
				Hospitals	2 in 10 miles	0	2	16.7	10	83.3	11.3	12.3
	Covington	70433	25	PCPs - Open	2 in 10 miles	167	25	100.0	0	0.0	0.6	0.8
				All Specialists - Open	2 in 10 miles	882	25	100.0	0	0.0	0.4	0.5
				Hospitals	2 in 10 miles	4	25	100.0	0	0.0	1.3	2.8
		70435	13	PCPs - Open	2 in 10 miles	0	13	100.0	0	0.0	4.4	5.3
				All Specialists - Open	2 in 10 miles	1	13	100.0	0	0.0	4.3	4.9
				Hospitals	2 in 10 miles	0	12	92.3	1	7.7	6.4	7.7
	Cut Off	70345	1	PCPs - Open	2 in 10 miles	8	1	100.0	0	0.0	1.0	3.1
				All Specialists - Open	2 in 10 miles	54	1	100.0	0	0.0	0.9	1.0
				Hospitals	2 in 10 miles	1	0	0.0	1	100.0	3.1	22.4
	Denham Springs	70726	1	PCPs - Open	2 in 10 miles	33	1	100.0	0	0.0	1.6	1.6
				All Specialists - Open	2 in 10 miles	161	1	100.0	0	0.0	1.1	1.5
				Hospitals	2 in 10 miles	1	1	100.0	0	0.0	1.9	3.7
	Destrehan	70047	3	PCPs - Open	2 in 10 miles	0	3	100.0	0	0.0	2.4	2.4
				All Specialists - Open	2 in 10 miles	12	3	100.0	0	0.0	0.8	0.8
				Hospitals	2 in 10 miles	0	0	0.0	3	100.0	3.0	12.1
	Folsom	70437	4	PCPs - Open	2 in 10 miles	3	4	100.0	0	0.0	3.3	3.3
				All Specialists - Open	2 in 10 miles	0	4	100.0	0	0.0	8.5	9.0
				Hospitals	2 in 10 miles	0	0	0.0	4	100.0	10.6	12.5
	Gonzales	70737	4	PCPs - Open	2 in 10 miles	64	4	100.0	0	0.0	1.0	1.4

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Access Detail By Zip Code

August 7, 2022

Access Analysis
- _9 In Network All Standard 2 - Open

Employee / Provider Groups
- In Network EEs (Aetna Medicare Plan (PPO) - 2023)
  - PCPs - Open
  - All Specialists - Open
  - Hospitals

All Employees												
State Name	City	Zip Code	Employee	Provider		Counts	With Access		Without Access		Average Distance	
			#	Group	Standard	#	#	%	#	%	1	2
Louisiana	Gonzales	70737	4	All Specialists - Open	2 in 10 miles	293	4	100.0	0	0.0	0.8	0.8
				Hospitals	2 in 10 miles	2	4	100.0	0	0.0	2.7	2.7
	Gramercy	70052	3	PCPs - Open	2 in 10 miles	3	3	100.0	0	0.0	0.5	0.5
				All Specialists - Open	2 in 10 miles	3	3	100.0	0	0.0	0.4	0.5
				Hospitals	2 in 10 miles	0	0	0.0	3	100.0	0.8	17.8
	Gretna	70053	23	PCPs - Open	2 in 10 miles	16	23	100.0	0	0.0	0.4	0.4
				All Specialists - Open	2 in 10 miles	44	23	100.0	0	0.0	0.3	0.4
				Hospitals	2 in 10 miles	0	23	100.0	0	0.0	2.2	2.5
		70054	2	PCPs - Open	2 in 10 miles	0	2	100.0	0	0.0	0.3	0.3
				All Specialists - Open	2 in 10 miles	0	2	100.0	0	0.0	0.1	0.1
				Hospitals	2 in 10 miles	0	2	100.0	0	0.0	2.5	3.0
		70056	34	PCPs - Open	2 in 10 miles	30	34	100.0	0	0.0	0.4	0.5
				All Specialists - Open	2 in 10 miles	124	34	100.0	0	0.0	0.3	0.3
				Hospitals	2 in 10 miles	1	34	100.0	0	0.0	2.0	3.8
	Hammond	70403	3	PCPs - Open	2 in 10 miles	76	3	100.0	0	0.0	0.9	1.2
				All Specialists - Open	2 in 10 miles	941	3	100.0	0	0.0	0.9	0.9
				Hospitals	2 in 10 miles	6	3	100.0	0	0.0	1.7	1.8
	Harvey	70058	41	PCPs - Open	2 in 10 miles	30	41	100.0	0	0.0	0.7	0.9
				All Specialists - Open	2 in 10 miles	69	41	100.0	0	0.0	0.8	0.9
				Hospitals	2 in 10 miles	0	41	100.0	0	0.0	1.7	2.5
	Husser	70442	2	PCPs - Open	2 in 10 miles	0	2	100.0	0	0.0	5.1	5.1
				All Specialists - Open	2 in 10 miles	0	2	100.0	0	0.0	5.1	5.1
				Hospitals	2 in 10 miles	0	0	0.0	2	100.0	10.2	10.3
	Independence	70443	3	PCPs - Open	2 in 10 miles	15	3	100.0	0	0.0	3.8	4.0
				All Specialists - Open	2 in 10 miles	87	3	100.0	0	0.0	3.7	3.7
				Hospitals	2 in 10 miles	1	3	100.0	0	0.0	4.0	8.3
	Kenner	70062	15	PCPs - Open	2 in 10 miles	14	15	100.0	0	0.0	0.6	0.7
				All Specialists - Open	2 in 10 miles	41	15	100.0	0	0.0	0.7	0.7
				Hospitals	2 in 10 miles	0	15	100.0	0	0.0	4.0	4.3
		70065	51	PCPs - Open	2 in 10 miles	58	51	100.0	0	0.0	0.4	0.5
				All Specialists - Open	2 in 10 miles	291	51	100.0	0	0.0	0.4	0.4
				Hospitals	2 in 10 miles	0	51	100.0	0	0.0	4.2	4.5
	Kentwood	70444	5	PCPs - Open	2 in 10 miles	3	5	100.0	0	0.0	4.4	4.5
				All Specialists - Open	2 in 10 miles	22	5	100.0	0	0.0	4.4	4.4
				Hospitals	2 in 10 miles	0	0	0.0	5	100.0	8.8	12.5
	LA Place	70068	10	PCPs - Open	2 in 10 miles	8	10	100.0	0	0.0	1.0	1.1
				All Specialists - Open	2 in 10 miles	111	10	100.0	0	0.0	0.9	1.0
				Hospitals	2 in 10 miles	0	0	0.0	10	100.0	11.8	13.5
	Lafayette	70508	1	PCPs - Open	2 in 10 miles	94	1	100.0	0	0.0	0.4	0.7
				All Specialists - Open	2 in 10 miles	1,095	1	100.0	0	0.0	0.4	0.4

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Access Detail By Zip Code

August 7, 2022

Access Analysis
- _9 In Network All Standard 2 - Open

Employee / Provider Groups
- In Network EEs (Aetna Medicare Plan (PPO) - 2023)
  - PCPs - Open
  - All Specialists - Open
  - Hospitals

All Employees												
State Name	City	Zip Code	Employee #	Provider Group	Provider Standard	Counts #	With Access #	With Access %	Without Access #	Without Access %	Average Distance 1	Average Distance 2
Louisiana	Lafayette	70508	1	Hospitals	2 in 10 miles	11	1	100.0	0	0.0	0.9	0.9
	Lafitte	70067	5	PCPs - Open	2 in 10 miles	5	5	100.0	0	0.0	1.5	1.5
				All Specialists - Open	2 in 10 miles	13	5	100.0	0	0.0	1.5	1.5
				Hospitals	2 in 10 miles	0	2	40.0	3	60.0	9.9	10.3
	Lockport	70374	1	PCPs - Open	2 in 10 miles	1	1	100.0	0	0.0	0.8	4.9
				All Specialists - Open	2 in 10 miles	4	1	100.0	0	0.0	0.8	1.8
				Hospitals	2 in 10 miles	0	0	0.0	1	100.0	10.8	11.7
	Loranger	70446	3	PCPs - Open	2 in 10 miles	3	3	100.0	0	0.0	3.5	3.5
				All Specialists - Open	2 in 10 miles	66	3	100.0	0	0.0	3.5	3.5
				Hospitals	2 in 10 miles	0	2	66.7	1	33.3	8.0	9.3
	Luling	70070	3	PCPs - Open	2 in 10 miles	16	3	100.0	0	0.0	0.9	0.9
				All Specialists - Open	2 in 10 miles	60	3	100.0	0	0.0	0.8	0.8
				Hospitals	2 in 10 miles	1	0	0.0	3	100.0	1.8	12.5
	Madisonville	70447	6	PCPs - Open	2 in 10 miles	1	6	100.0	0	0.0	1.8	3.0
				All Specialists - Open	2 in 10 miles	4	6	100.0	0	0.0	1.1	1.2
				Hospitals	2 in 10 miles	0	6	100.0	0	0.0	5.2	7.0
	Mandeville	70448	7	PCPs - Open	2 in 10 miles	2	7	100.0	0	0.0	2.1	2.2
				All Specialists - Open	2 in 10 miles	59	7	100.0	0	0.0	0.6	0.8
				Hospitals	2 in 10 miles	0	7	100.0	0	0.0	3.2	3.2
		70471	14	PCPs - Open	2 in 10 miles	18	14	100.0	0	0.0	1.3	1.3
				All Specialists - Open	2 in 10 miles	104	14	100.0	0	0.0	0.6	1.0
				Hospitals	2 in 10 miles	0	14	100.0	0	0.0	2.1	2.2
	Marrero	70072	144	PCPs - Open	2 in 10 miles	110	144	100.0	0	0.0	1.0	1.1
				All Specialists - Open	2 in 10 miles	505	144	100.0	0	0.0	1.1	1.1
				Hospitals	2 in 10 miles	3	144	100.0	0	0.0	2.1	2.2
		70073	7	PCPs - Open	2 in 10 miles	0	7	100.0	0	0.0	0.1	0.1
				All Specialists - Open	2 in 10 miles	0	7	100.0	0	0.0	0.2	0.2
				Hospitals	2 in 10 miles	0	7	100.0	0	0.0	1.2	1.3
	Metairie	70001	47	PCPs - Open	2 in 10 miles	60	47	100.0	0	0.0	0.5	0.5
				All Specialists - Open	2 in 10 miles	305	47	100.0	0	0.0	0.3	0.4
				Hospitals	2 in 10 miles	1	47	100.0	0	0.0	1.1	1.6
		70002	17	PCPs - Open	2 in 10 miles	22	17	100.0	0	0.0	0.2	0.3
				All Specialists - Open	2 in 10 miles	166	17	100.0	0	0.0	0.2	0.2
				Hospitals	2 in 10 miles	0	17	100.0	0	0.0	1.2	1.7
		70003	58	PCPs - Open	2 in 10 miles	4	58	100.0	0	0.0	0.7	0.8
				All Specialists - Open	2 in 10 miles	20	58	100.0	0	0.0	0.6	0.7
				Hospitals	2 in 10 miles	0	58	100.0	0	0.0	2.1	2.6
		70004	1	PCPs - Open	2 in 10 miles	0	1	100.0	0	0.0	0.2	0.2
				All Specialists - Open	2 in 10 miles	0	1	100.0	0	0.0	0.4	0.4
				Hospitals	2 in 10 miles	0	1	100.0	0	0.0	1.0	1.0

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Access Detail By Zip Code

August 7, 2022

Access Analysis
- _9 In Network All Standard 2 - Open

Employee / Provider Groups
- In Network EEs (Aetna Medicare Plan (PPO) - 2023)
  - PCPs - Open
  - All Specialists - Open
  - Hospitals

All Employees												
State Name	City	Zip Code	Employee #	Provider		Counts	With Access		Without Access		Average Distance	
				Group	Standard	#	#	%	#	%	1	2
Louisiana	Metairie	70005	42	PCPs - Open	2 in 10 miles	10	42	100.0	0	0.0	0.5	0.5
				All Specialists - Open	2 in 10 miles	50	42	100.0	0	0.0	0.3	0.4
				Hospitals	2 in 10 miles	0	42	100.0	0	0.0	2.6	2.7
		70006	12	PCPs - Open	2 in 10 miles	105	12	100.0	0	0.0	0.2	0.3
				All Specialists - Open	2 in 10 miles	444	12	100.0	0	0.0	0.2	0.2
				Hospitals	2 in 10 miles	1	12	100.0	0	0.0	0.6	1.3
		70011	2	PCPs - Open	2 in 10 miles	0	2	100.0	0	0.0	0.2	0.3
				All Specialists - Open	2 in 10 miles	0	2	100.0	0	0.0	0.1	0.1
				Hospitals	2 in 10 miles	0	2	100.0	0	0.0	1.4	1.7
		70033	1	PCPs - Open	2 in 10 miles	0	1	100.0	0	0.0	0.7	0.7
				All Specialists - Open	2 in 10 miles	0	1	100.0	0	0.0	0.3	0.3
				Hospitals	2 in 10 miles	0	1	100.0	0	0.0	2.3	2.3
	Morgan City	70380	1	PCPs - Open	2 in 10 miles	17	1	100.0	0	0.0	0.6	0.6
				All Specialists - Open	2 in 10 miles	231	1	100.0	0	0.0	0.4	0.4
				Hospitals	2 in 10 miles	1	0	0.0	1	100.0	1.0	20.0
	Napoleonville	70390	2	PCPs - Open	2 in 10 miles	2	2	100.0	0	0.0	0.9	2.0
				All Specialists - Open	2 in 10 miles	4	2	100.0	0	0.0	0.9	0.9
				Hospitals	2 in 10 miles	1	0	0.0	2	100.0	1.9	10.8
	New Orleans	70114	7	PCPs - Open	2 in 10 miles	35	7	100.0	0	0.0	0.5	0.5
				All Specialists - Open	2 in 10 miles	91	7	100.0	0	0.0	0.4	0.4
				Hospitals	2 in 10 miles	0	7	100.0	0	0.0	2.6	3.0
		70117	1	PCPs - Open	2 in 10 miles	16	1	100.0	0	0.0	0.5	0.5
				All Specialists - Open	2 in 10 miles	19	1	100.0	0	0.0	0.6	0.6
				Hospitals	2 in 10 miles	0	1	100.0	0	0.0	2.7	3.0
		70118	4	PCPs - Open	2 in 10 miles	82	4	100.0	0	0.0	0.5	0.5
				All Specialists - Open	2 in 10 miles	356	4	100.0	0	0.0	0.3	0.4
				Hospitals	2 in 10 miles	0	4	100.0	0	0.0	1.9	2.0
		70119	2	PCPs - Open	2 in 10 miles	35	2	100.0	0	0.0	0.5	0.5
				All Specialists - Open	2 in 10 miles	111	2	100.0	0	0.0	0.3	0.4
				Hospitals	2 in 10 miles	2	2	100.0	0	0.0	0.6	0.6
		70121	22	PCPs - Open	2 in 10 miles	6	22	100.0	0	0.0	0.4	0.4
				All Specialists - Open	2 in 10 miles	61	22	100.0	0	0.0	0.2	0.3
				Hospitals	2 in 10 miles	2	22	100.0	0	0.0	0.7	0.7
		70122	5	PCPs - Open	2 in 10 miles	16	5	100.0	0	0.0	0.8	0.8
				All Specialists - Open	2 in 10 miles	51	5	100.0	0	0.0	0.5	0.7
				Hospitals	2 in 10 miles	0	5	100.0	0	0.0	2.8	2.8
		70123	55	PCPs - Open	2 in 10 miles	2	55	100.0	0	0.0	1.1	1.1
				All Specialists - Open	2 in 10 miles	43	55	100.0	0	0.0	0.5	0.5
				Hospitals	2 in 10 miles	0	55	100.0	0	0.0	3.1	3.2
		70124	3	PCPs - Open	2 in 10 miles	5	3	100.0	0	0.0	0.8	0.9

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Access Detail By Zip Code

August 7, 2022

Access Analysis
_9 In Network All Standard 2 - Open

Employee / Provider Groups
In Network EEs (Aetna Medicare Plan (PPO) - 2023)
PCPs - Open
All Specialists - Open
Hospitals

All Employees												
State Name	City	Zip Code	Employee #	Provider Group	Provider Standard	Counts #	With Access #	With Access %	Without Access #	Without Access %	Average Distance 1	Average Distance 2
Louisiana	New Orleans	70124	3	All Specialists - Open	2 in 10 miles	34	3	100.0	0	0.0	0.4	0.5
				Hospitals	2 in 10 miles	0	3	100.0	0	0.0	2.1	2.1
		70127	2	PCPs - Open	2 in 10 miles	34	2	100.0	0	0.0	0.4	0.4
				All Specialists - Open	2 in 10 miles	93	2	100.0	0	0.0	0.3	0.4
				Hospitals	2 in 10 miles	1	2	100.0	0	0.0	0.5	5.0
		70129	2	PCPs - Open	2 in 10 miles	1	2	100.0	0	0.0	1.8	3.2
				All Specialists - Open	2 in 10 miles	9	2	100.0	0	0.0	1.1	1.8
				Hospitals	2 in 10 miles	0	2	100.0	0	0.0	4.0	6.8
		70131	3	PCPs - Open	2 in 10 miles	3	3	100.0	0	0.0	1.0	1.7
				All Specialists - Open	2 in 10 miles	32	3	100.0	0	0.0	0.7	0.8
				Hospitals	2 in 10 miles	0	3	100.0	0	0.0	3.0	3.3
		70174	1	PCPs - Open	2 in 10 miles	0	1	100.0	0	0.0	0.1	0.2
				All Specialists - Open	2 in 10 miles	0	1	100.0	0	0.0	0.2	0.2
				Hospitals	2 in 10 miles	0	1	100.0	0	0.0	2.8	3.8
	Norco	70079	1	PCPs - Open	2 in 10 miles	4	1	100.0	0	0.0	0.9	0.9
				All Specialists - Open	2 in 10 miles	11	1	100.0	0	0.0	0.9	0.9
				Hospitals	2 in 10 miles	0	0	0.0	1	100.0	6.1	13.7
	Pearl River	70452	2	PCPs - Open	2 in 10 miles	0	2	100.0	0	0.0	5.7	5.7
				All Specialists - Open	2 in 10 miles	2	2	100.0	0	0.0	2.1	2.1
				Hospitals	2 in 10 miles	0	2	100.0	0	0.0	7.3	7.6
	Ponchatoula	70454	13	PCPs - Open	2 in 10 miles	4	13	100.0	0	0.0	2.4	2.8
				All Specialists - Open	2 in 10 miles	32	13	100.0	0	0.0	2.3	2.3
				Hospitals	2 in 10 miles	0	13	100.0	0	0.0	3.6	4.5
	Prairieville	70769	1	PCPs - Open	2 in 10 miles	13	1	100.0	0	0.0	1.7	1.8
				All Specialists - Open	2 in 10 miles	58	1	100.0	0	0.0	1.7	1.7
				Hospitals	2 in 10 miles	1	1	100.0	0	0.0	3.5	7.0
	Raceland	70394	1	PCPs - Open	2 in 10 miles	9	1	100.0	0	0.0	1.2	1.2
				All Specialists - Open	2 in 10 miles	69	1	100.0	0	0.0	0.7	0.7
				Hospitals	2 in 10 miles	0	0	0.0	1	100.0	11.0	11.2
	Robert	70455	2	PCPs - Open	2 in 10 miles	2	2	100.0	0	0.0	0.9	0.9
				All Specialists - Open	2 in 10 miles	9	2	100.0	0	0.0	0.9	0.9
				Hospitals	2 in 10 miles	0	2	100.0	0	0.0	5.2	7.7
	Saint Amant	70774	1	PCPs - Open	2 in 10 miles	1	1	100.0	0	0.0	1.9	4.0
				All Specialists - Open	2 in 10 miles	2	1	100.0	0	0.0	1.9	1.9
				Hospitals	2 in 10 miles	0	1	100.0	0	0.0	5.9	5.9
	Saint Rose	70087	3	PCPs - Open	2 in 10 miles	2	3	100.0	0	0.0	0.9	0.9
				All Specialists - Open	2 in 10 miles	1	3	100.0	0	0.0	0.9	3.2
				Hospitals	2 in 10 miles	0	3	100.0	0	0.0	5.0	7.5
	Slidell	70458	4	PCPs - Open	2 in 10 miles	51	4	100.0	0	0.0	0.4	0.4
				All Specialists - Open	2 in 10 miles	415	4	100.0	0	0.0	0.2	0.3

Continued on next page...

Access Detail By Zip Code

August 7, 2022

Access Analysis
_9 In Network All Standard 2 - Open

Employee / Provider Groups
In Network EEs (Aetna Medicare Plan (PPO) - 2023)
PCPs - Open
All Specialists - Open
Hospitals

All Employees												
State Name	City	Zip Code	Employee #	Provider		Counts	With Access		Without Access		Average Distance	
				Group	Standard	#	#	%	#	%	1	2
Louisiana	Slidell	70458	4	Hospitals	2 in 10 miles	3	4	100.0	0	0.0	0.8	1.2
		70460	1	PCPs - Open	2 in 10 miles	3	1	100.0	0	0.0	0.5	0.5
				All Specialists - Open	2 in 10 miles	24	1	100.0	0	0.0	0.5	0.5
				Hospitals	2 in 10 miles	0	1	100.0	0	0.0	2.7	3.8
		70461	1	PCPs - Open	2 in 10 miles	11	1	100.0	0	0.0	1.1	1.1
				All Specialists - Open	2 in 10 miles	116	1	100.0	0	0.0	1.1	1.1
				Hospitals	2 in 10 miles	0	1	100.0	0	0.0	1.7	1.7
	Springfield	70462	1	PCPs - Open	2 in 10 miles	0	1	100.0	0	0.0	6.1	6.6
				All Specialists - Open	2 in 10 miles	46	1	100.0	0	0.0	3.7	3.7
				Hospitals	2 in 10 miles	0	1	100.0	0	0.0	9.0	9.0
	Thibodaux	70301	4	PCPs - Open	2 in 10 miles	39	4	100.0	0	0.0	1.3	1.4
				All Specialists - Open	2 in 10 miles	553	4	100.0	0	0.0	1.1	1.1
				Hospitals	2 in 10 miles	1	0	0.0	4	100.0	2.1	13.1
	Tickfaw	70466	1	PCPs - Open	2 in 10 miles	0	1	100.0	0	0.0	4.3	4.4
				All Specialists - Open	2 in 10 miles	0	1	100.0	0	0.0	2.9	2.9
				Hospitals	2 in 10 miles	0	1	100.0	0	0.0	4.4	5.4
	Westwego	70094	50	PCPs - Open	2 in 10 miles	17	50	100.0	0	0.0	0.7	0.7
				All Specialists - Open	2 in 10 miles	52	50	100.0	0	0.0	0.6	0.8
				Hospitals	2 in 10 miles	0	50	100.0	0	0.0	3.5	3.6
		70096	2	PCPs - Open	2 in 10 miles	0	2	100.0	0	0.0	0.2	0.2
				All Specialists - Open	2 in 10 miles	0	2	100.0	0	0.0	0.3	0.3
				Hospitals	2 in 10 miles	0	2	100.0	0	0.0	2.6	2.6
Grand Totals			832	PCPs - Open	2 in 10 miles	1,430	828	99.5	4	0.5	1.0	1.2
				All Specialists - Open	2 in 10 miles	9,156	829	99.6	3	0.4	0.9	1.0
				Hospitals	2 in 10 miles	49	774	93.0	58	7.0	2.9	3.7

Outside of Service Area Detail By Zip Code

August 7, 2022

All EEs

AdultPCP

Aetna Medicare Plan (PPO) - 2023

All Service Areas			
State Name	City	Zip Code	Employee #
Louisiana	Belle Chasse	70037	4
	Bogalusa	70427	2
	Franklinton	70438	7
Mississippi	Bay Saint Louis	39520	2
	Kokomo	39643	1
	Picayune	39466	2
	Poplarville	39470	1
Grand Totals			19

State of Louisiana

James J. Donelon

COMMISSIONER OF INSURANCE

CERTIFICATE OF AUTHORITY

Whereas, the AETNA LIFE INSURANCE COMPANY located at Connecticut has applied for a certificate of authority and made the filings required of such Insurer. Therefore, I, James J Donelon, the undersigned Commissioner of Insurance, do hereby certify that the said AETNA LIFE INSURANCE COMPANY is authorized to transact its appropriate business of Health and accident; Life Insurance in this State, in accordance with the laws thereof. This certificate shall remain in effect until cancelled, suspended, revoked or the renewal thereof refused.

In Testimony Whereof, I hereunto subscribe my name,

and affix the seal of my office at Baton Rouge this

1st day of January A.D 2010.

James J. Donelon
Commissioner of Insurance

Amended: Original certificate effective date March 14, 1899

Aetna Subcontractors for MAPD

Subcontractor	Corporate Location	Scope	Domestic or Offshore	Doing business since date
Accenture	New York, NY	Data entry of individual and group enrollments. Processes fallout of electronic individual enrollment feeds only. Index of all work. If we identify an enrollment for Tier II onshore processing, enrollments directed to onshore via AHAP system for processing onshore in Blue Bell, PA. Complete PCP lookups for Enrollments with incorrect PCP IDs on enrollment forms and process.	Offshore	2006
Access2Care	Greenwood Village, CO	Provides non-emergency medical transportation, more specifically, ambulatory (sedan), wheelchair access and stretcher van transportation.	Domestic	2013
Aerogami	Wellesly, MA	Provides contact cards for members. Members text to a number and receive download for mobile device.	Domestic	2019
Akorbi	Plano, TX	Provides written translation, interpretation, digital remediation and video interpretation.	Both (Akorbi performs no work for Medicare offshore. Akorbi performs most Aetna work onshore, except for Aetna international projects.)	2007
American Specialty Health, Inc. (ASH)	San Diego, CA	Manages the Healthyroads Coaching programs that provide members with ongoing support and coaching. Manages the supplemental acupuncture, chiro, naturopathy and massage benefits.	Domestic	2006
Alorica	Irvine, CA	Provides Medicare Part D pharmacy help Desk and Medicare commercial member calls	Domestic	2014
Arna Marketing Group, Inc.	Branchburg, NJ	Enterprise-wide print and direct mail communications.	Domestic	2006
BeneLynk	Milford, CT	Performs analysis on potential dual-eligible members based on the CMS Monthly Membership Report and Model Operating Report and analyzes Aetna membership	Domestic	2022

Aetna Subcontractors for MAPD

Subcontractor	Corporate Location	Scope	Domestic or Offshore	Doing business since date
		demographic to make an outreach to potential dual eligible members.		
Care Centrix (Florida Only)	Hartford, CT	CareCentrix delegates for home health services. They accept delegation for network contracting and service and patient management/utilization management for members in the FL market only. Aetna maintains claim processing delegation.	Domestic	2011
Change Healthcare (formerly EquiClaim, Inc)	Nashville	Performs medical claim overpayment recovery for the following services: hospital bill audits, DRG audits and high-cost drug. Printing and mailing of member checks and EOBs.	Domestic	2000
Clarity Software Solutions, Inc.	Madison, CT	Printing and fulfillment of ID cards.	Domestic	2018
Cognizant Technology Solutions	Teaneck, NU	Benefits and clinical/formulary rule testing, query validation.	Both	2018
Concentrix	Fremont, CA	Claims processors will be using Aetna systems, and Aetna/CMS policy and procedures to process or correct paper and electronic claims. Processors are responsible for verifying various member and provider details including but not limited to member eligibility, provider contracting information, authorizations, standard applicable rates and legislative mandates and exceptions. The processors will either correct, pay, or deny claims. Processors will process the claim using the appropriate processing rational, or where applicable, escalate the claim for more information as established in the processing guidelines provided in training and documented in the Aetna online claims reference manuals.	Both	2002
Conduent	Florham Park, NJ	Mailroom (open mail, sort and scan), fax/image sort, data capture of enrollment forms and member correspondence, and storage of images. Index member correspondence (first name, last name, member number, MBI) and route to WeQ for manual work by enrollment.	Both	2007

Aetna Subcontractors for MAPD

Subcontractor	Corporate Location	Scope	Domestic or Offshore	Doing business since date
		Enrollment forms are fully data captured and work sent to Aetna/CVS on a data file. The file is processed into the enrollment system.		
Conduent Credit Balance Solutions	Hunt Valley, MD	Performs medical claim overpayment recovery for the following services — hospital credit balance	Domestic	2006
Connexion Point, LLC	Sandy, UT San Antonio, TX	Telesales support for pre-enrollment calls by prospective members with questions regarding the plan benefits, upcoming changes, etc. Connexion also provides support for RSVPs for scheduled informational live meetings or conference calls. Includes support for: • Inbound telephonic pre-enrollment support • Inbound telephonic RSVP support • Inbound telephonic enrollment (select plan sponsors only) • Inbound telephonic “opt-out” support • Outbound telephonic pre-enrollment support • Outbound telephonic RSVP support • Outbound provider outreach support.	Domestic	2016
Continuum	Dallas, Texas	Pharmacy call center support	Domestic	2007
Cotiviti	Blue Bell, PA	Performs medical claim overpayment recovery for the following services: coordination of benefits, contract compliance, data mining, duplicates, cross platform drug, high drug cost, retro terminations, implant audits, DRG audits, short stay audits and specialty audits (SNF, IRF, RUGS).	Domestic	2000
CQ Fluency	Hackensack, NJ	Provides written translation and digital remediation.	Domestic	2013
Element 3	Denver, CO	Value added item and service. Connects members to activity/social clubs in person or online.	Domestic	2020

Aetna Subcontractors for MAPD

Subcontractor	Corporate Location	Scope	Domestic or Offshore	Doing business since date
End-Game Strategy, Inc.	Berlin, CT	Performs medical claim overpayment recovery for the following services: contract compliance, duplicate claim review and data mining.	Domestic	2010
Equian (purchased by Optum)	Warrenville, IL Indianapolis, IN	Performs medical claim overpayment recovery for the following services: contract compliance, duplicate payment, data mining, retro termination, hospital bill audit, subrogation and works compensation.	Domestic	2004
eviCore Healthcare	Bluffton, SC	Utilization management for the following services: •Outpatient diagnostic imaging procedures such as MRI/MRA, nuclear cardiology, PET scan and CT scan, including CTA •Non-emergent outpatient stress echocardiology •Non-emergent outpatient diagnostic left and right catheterization •Insertion, removal and upgrade of electric implantable cardioverter defibrillator, cardiac resynchronization therapy defibrillator and implantable pacemaker •Polysomnography (attended sleep studies) •Interventional pain management •Outpatient radiation therapy	Domestic	2003
EXL Health (formerly ScioHealth Analytics. Purchased by EXL Health)	New York, NY	Performs medical claim overpayment recovery for the following services: hospital bill audits, DRG audits and outpatient audits.	Domestic	2019
EXL Service Holdings, Inc.	Corporate Headquarters: 320 Park Avenue, New York, NY 10022	Clinical services including precertification intake, Infertility, outreach calls, outreach for alerts, utilization management, Behavioral Health and identified gaps in treatment. Pre-determination of services, clinical claim review and HEDIS abstraction for NCQA accreditation.	Offshore	2012
First Mile Care	Houston, TX	First Mile Care serves as the CMS recognized supplier administer the CMS required Medicare diabetes prevention program to eligible members.	Domestic	2021

Aetna Subcontractors for MAPD

Subcontractor	Corporate Location	Scope	Domestic or Offshore	Doing business since date
Fiserv	Brookfield, WI	Print production	Domestic	2002
FoodSmart	San Francisco, CA	Provides healthy eating assessment and subsequent dietician evaluations	Domestic	2021
GA Foods	St. Petersburg, FL	Provides both in-patient post-discharge and chronic meal delivery of frozen meals designed for those with diabetes, hypertension and cardiac restrictions.	Domestic	2017
Health Management Systems	Irving, TX	Performs medical claim overpayment recovery for the following services: hospital bill audit, DRG audit and short stay audit.	Domestic	2009
Hinduja Global Solutions Limited (HGSL)	Lisle, IL	Claims processors use Aetna systems and Aetna/CMS policy and procedures to process or correct paper and electronic claims. Processors verify various member and provider details including, but not limited to, member eligibility, provider contracting information, authorizations, standard applicable rates and legislative mandates and exceptions. The processors will either correct, pay or deny claims using the appropriate processing rational. Where applicable, processors escalate the claim for more information as established in the processing guidelines provided in training and documented in the Aetna online claims reference manuals.	Both	2000
Independent Living Systems (ILS) – Florida Only	Miami, Fl	Provides both in-patient post-discharge and chronic meal delivery of frozen meals designed for those with diabetes, hypertension and cardiac restrictions.	Domestic – Florida Only	2019
Intrado	Omaha, NE	Outbound IVR	Domestic	2020
Iron Mountain, Inc.	Boston, MA	Records archiving, retrieving, transportation and destruction services.	Domestic	Circa 1995
Language Line	Monterey, CA	Over-the-phone interpretation, onsite interpretation and video interpretation	Both	2019
LexisNexus	Menlo Park, CA	Provides OIG excluded provider information.	Domestic	2017
LifeStation	Union, NJ	Personal emergency response system benefit	Both	2021 - Discoun

Aetna Subcontractors for MAPD

Subcontractor	Corporate Location	Scope	Domestic or Offshore	Doing business since date
				t, 2019 - Full benefit
Lumo Labs (Lumosity)	San Francisco, CA	Brain agility app for brain games that may improve cognitive abilities	Domestic	2019
Matrix Medical Network (Community Care Health Network, LLC dba Matrix Medical Network (National Vendor))	Scottsdale, AZ	In home assessments — includes chronic care management, HEDIS/STAR screenings, SDOH, medication review and coordination of care.	Domestic	2012
MDLive	Miramar, FL	Behavioral health telehealth vendor for the Aetna Medicare Group business	Domestic	2021
Morely	Saginaw, MI	Outbound call campaigns	Domestic	2018
MyNEXUS	Brentwood, TN	myNEXUS delegates for home health services. They accept delegation for claims processing/payment, network contracting and service and patient management/utilization management for Medicare members only in TX, GA, KY, MO, OH, OK, PA, VA, WV and FL markets only. Aetna maintains all appeals.	Domestic	2020
Nations Hearing	Plantation, FL	Hearing aid supplemental benefit	Domestic	2021
National Imaging Associates	Columbia, MD	Utilization management of physical medicine services in the states of DE, NJ, NY PA and WV.	Domestic	2018
OmniClaim, Inc. (Purchased by Optum)	Woburn, MA	Performs medical claim overpayment recovery for the following services: DRG audits, implant audits and outpatient audits.	Domestic	2009
O'Neil Data Solution	Plano, TX	Printing, fulfillment	Domestic	2015
Optum Health (NC, SC, DC, VA, GA, IL markets.)	Golden Valley. MN	Optum Health delegates for physical and occupational therapy services. They accept delegation for claims processing/payment, network contracting and service and patient management/utilization management for	Domestic	2012

Aetna Subcontractors for MAPD

Subcontractor	Corporate Location	Scope	Domestic or Offshore	Doing business since date
		members in the NC, SC, DC, VA, GA, and IL markets.		
OptumInsight Inc.	Franklin, TN	Performs medical claim overpayment recovery for the following services: hospital credit balance, coordination of benefits, contract compliance, duplicate, data mining, high-cost drug, retro termination and PRS (Payment Resolution Services) — client referred overpayments.	Both	1996
On24	San Francisco, CA	Virtual webcasts available.	Domestic	2020
OrthoNet (CT market only.)	White Plains, NY	OrthoNet delegates for physical and occupational therapy services. They accept delegation for claims processing/payment, network contracting and service and patient management/utilization management for members in the CT market only.	Domestic	2009
OutcomesMTM	West Des Moines, IA	Management services including Comprehensive Medication Reviews and Targeted Medication Reviews	Domestic	2017
Papa, Inc	Miami, FL	Social needs - provides adult companions to assist members with daily activities (i.e., tech help, games, companionship)	Domestic	2019
Quest Diagnostics	Secaucus, NJ	Biometrics services to ActiveHealth Management's customers (UBS/FMC/State of NJ/State of IN/State of TN/and Better You Better OH state). Data delivery services to ActiveHealth direct and indirect customers (36 customers in 2021).	Domestic	2010
Rawlings Company	La Grange, KY	Performs medical claim overpayment recovery for the following services: coordination of benefits, cross platform drug, high-cost drug, subrogation and workers' compensation.	Domestic	1998
Scio Analytics	Miramar, FL	Performs CVS retail pharmacy audits.	Domestic	2016
Signify Health	Dallas, TX	In home assessments — include chronic care management, HEDIS/STAR screenings, SDOH, medication review and coordination of care.	Domestic	2012

Aetna Subcontractors for MAPD

Subcontractor	Corporate Location	Scope	Domestic or Offshore	Doing business since date
Silverlink Communications	Burlington, MA	Delivery of IVRs to members and faxes to prescribers in support of member conversions from 30-90 refills	Domestic	2013
SimplTech	Dallas, TX	Provide Reminder Rosie device to assist with everyday reminders - voice activated and customizable	Domestic	2022
Solera	Phoenix, AZ	Solera Health provides a network of CMS recognized health coaches and dieticians to administer the CMS required Medicare diabetes prevention program to eligible members.	Domestic	2018
Solutran	Minneapolis, MN	Provide debit cards for members to access monthly allowances they can use at select retailers to purchase approved health food options or pay for approved utilities	Domestic	2020
SPH Analytics	Arlington, TX	Member satisfaction survey — our telephone-based Aetna Performance Tracking Member Satisfaction Survey — a comprehensive assessment of how well our health plans meet member expectations.	Domestic	1999
Teladoc	Lewisville, TX	Resolves medical issues 24/7 through the convenience of phone or video consultations. It provides patients with access to a national network of physicians who can diagnose, treat and prescribe medication for many common medical issues.	Domestic	2011
Tivity Health	Franklin, TN	Administers SilverSneakers.	Domestic	2006
Trend Health Partners	Hunt Valley, MD	Performs medical claim overpayment recovery for the following services — hospital credit balance	Domestic	2020
Welltok	Denver, CO	Administration of the Health Risk Assessment survey to all new members within 90 days of enrollment and annually thereafter as required by CMS.	Domestic	2017
WiPro	East Brunswick, NJ	Provides access to CMS database so we can check Medicare Beneficiary Identifier (MBI) electronically via a file or on demand lookup.	Both	2006

Implementation solutions overview

Submitted to

Jefferson Parish

aetna®

Table of contents

The proactive implementation team approach

We understand that implementing new health benefits packages can present many challenges. That's why we provide you with a whole team of experts to help guide you through a smooth transition.

You will have many questions along the way, including:

- How are business and member deliverables managed?
- How and when are benefit changes communicated to employees?
- What is the timing of the open enrollment period?
- How is the exchange of key information facilitated?
- How and when will providers be notified of the plan?

We help you address these questions by combining a team of experts supported by effective project management tools. This approach, in place for over 30 years and refined annually through our continuous quality initiatives, sets the foundation for a long-lasting relationship with you.

Collaboration and accountability

Our implementation team approach establishes a collaborative environment through our partnership with you and your business partners. Your Implementation Manager leads a team of our subject matter experts and Jefferson Parish representatives. While each implementation team member contributes their unique talents to ensure a seamless transition, the Implementation Manager has overall accountability to you.

Your Implementation Manager develops an Implementation Management Plan that outlines tasks and target completion date specific to each team member. The Implementation Manager carefully monitors the plan's progress and other project management tools. Through regularly scheduled meetings and conference calls,the team provides updates and the status and resolution of issues raised during the transition.

Continuous commitment

We remain committed in our service to you. Several members of the implementation team remain actively involved with the ongoing service of your account.

The implementation team — roles and responsibilities

Throughout the project, the implementation team members work together toward a seamless transition of your benefits program. This team includes thefollowing representatives:

Jefferson Parish

We recommend that the implementation team includes Jefferson Parish representatives from the following areas:

- Employee benefits
- Eligibility
- Finance
- Human resources
- Communications

Your Aetna team

Your implementation team includes the following Aetna members:

- Wendy Smitherman, Sales Vice President, Aetna Retiree Markets
  - Facilitates and oversees the overall process, contracts, and plan design(s)

- Medicare Advantage Account Director
  - Primary Aetna contact throughout implementation
  - Coordinates open enrollment activities
  - Provides ongoing account management after the plan effective date

- Medicare Advantage Plan Sponsor Liaison (PSL)
  - Creates and maintains the Plan Sponsor Profile tool for Member Services
  - Facilitates the ID card process
  - Serves as a Plan Sponsor contact for benefit questions and escalated or complex member issues

- Member Service Center
  - Your dedicated toll-free phone number provides member services support
  - Provides personalized service and claims processing
  - Coordinates audits

- Implementation Manager
  - Directs implementation activities
  - Oversees activities of all Aetna areas

- Eligibility
  - Maintains member eligibility data
  - Coordinates production and ID card mailings

- Billing
  - Codes billing rates into Aetna systems
  - Prepares billing statements

Assumptions

We have provided an overall project management timeline that includes key events based on the information and assumptions.

- The decision to implement the proposed benefits program will be made by 09/01/2022
- The effective date will be 01/01/2023
- Benefits will be those described in the proposal
- Eligibility certification:
  - Aetna will certify eligibility for medical and pharmacy claims
  - The Jefferson Parish will report eligibility via optional / electronic file
- MAPD Plan confirmation – Medicare Advantage with Prescription Drug (MAPD)> plan has been provided within this Implementation Solutions Overview.
  - Medicare Advantage Plan with Prescription Drug (MAPD)
    - The Aetna Medicare Plan ESA PPO and Medicare Prescription Drug plans will be on a full-risk basis
- Billing methods:
  - List or Summary Style Invoice
- Aetna pays claims incurred on and after the effective date of 01/01/2023
- The prior carrier will pay claims runoff incurred before 01/01/2023

Your implementation process to ensure a seamless transition

Plan (Sep-Oct)

Develop & monitor project plan

Conduct status calls

Support (Sep-Oct)

Send member communications

Host retiree meetings

Validate (Nov)

Test systems

Load eligibility/ enroll members

Post-implementation (Jan-Feb)

Evaluate implementation

Debrief

2022 SEP OCT NOV DEC

Go live 1/1/2023

Discover & define (Sep)

Collect info, confirm strategy

Engage implementation team

Determine roles & responsibilities

Set expectations

Technology and member setup (Sep-Oct)

Finalize plan design

Confirm account structure & eligibility requirements

Complete system setup

Train Member Services

Communicate post-enrollment (Dec)

Mail ID cards

Distribute CMS-required communications

Mail welcome kit

Send provider reminders

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Jefferson Parish
MAPD implementation plan & proposed timing

Activity	Responsibility	Date
Notice of business award		**09/01/22**
Project strategy and scope		
Conduct implementation Welcome meeting	Jefferson Parish, Aetna implementation & account teams	09/14/22
Member enrollment/communication strategy		
Outline communications and design strategy	Aetna, Jefferson Parish	09/14/22
Review member communications	Aetna, Jefferson Parish	09/14/22
Announcement letter mailed	Jefferson Parish, with Aetna marketing support	09/22/22
Verify/obtain mailing address list	Aetna, Jefferson Parish	09/22/22
Aetna informational mailings begin	Aetna marketing	09/26/22
Mail plan confirmation/acceptance letters to retirees	Aetna marketing	12/01/22
Mail member post-enrollment kits with SOC	Aetna marketing	12/16/22
Retiree meetings		
Start retiree education meetings	Aetna	10/18/22
Enrollment period begins	Aetna, Jefferson Parish	11/01/22
Member Service Center		
Confirm service center & go-live date	Aetna account team, Jefferson Parish	09/19/22
Member Services go live	Aetna Medicare member services	12/02/22
Begin processing post-effective date claims	Aetna Medicare member services	01/01/23
Eligibility		
Discuss enrollment requirements & process	Aetna eligibility consultant, Jefferson Parish	09/14/22
Submit eligibility production file	Jefferson Parish	11/22/22
Receive enrollment approval from CMS	Aetna Medicare enrollment	12/01/22
ID cards		
Confirm ID card format & requirements	Jefferson Parish, plan sponsor liaison	09/14/22
Release ID cards, mail to retirees	Plan sponsor liaison	12/02/22
Contracts & agreements		
Obtain signed Medicare master application (NB008)	Aetna account team, Jefferson Parish	09/29/22
Provide Medicare Group Agreement (MGA)	Aetna account team	11/11/22
Plan benefit setup		
Discuss account structure	Aetna account manager, Jefferson Parish	09/14/22
Confirm pharmacy benefits & requirements	Aetna account manager, Jefferson Parish	09/14/22
Confirm system setup	Aetna analyst	11/10/22
Billing		
Deliver invoice/bill	Aetna billing premium consultant	12/15/22
Effective date		**01/01/23**

Label Name2	GPI 14 Strength Cod	Sum of Total Rx 2021	Tier
AMLODIPINE TAB 5MG	34000003100330	2941915	1
ATORVASTATIN TAB 40MG	39400010100330	2725820	1
PANTOPRAZOLE TAB 40MG	49270070100620	2509896	1
ATORVASTATIN TAB 20MG	39400010100320	2419666	1
TAMSULOSIN CAP 0.4MG	56852070100110	2335293	2
AMLODIPINE TAB 10MG	34000003100340	2271441	1
OMEPRAZOLE CAP 20MG	49270060006520	2268722	2
GABAPENTIN CAP 300MG	72600030000130	1940618	2
ATORVASTATIN TAB 10MG	39400010100310	1876624	1
ELIQUIS TAB 5MG	83370010000330	1861289	3
CLOPIDOGREL TAB 75MG	85158020100320	1777989	1
METFORMIN TAB 500MG	27250050000320	1774237	1
FUROSEMIDE TAB 20MG	37200030000305	1763069	1
TRAMADOL HCL TAB 50MG	65100095100320	1679681	2
METOPROL SUC TAB 25MG ER	33200030057510	1588402	2
OMEPRAZOLE CAP 40MG	49270060006530	1569424	2
LOSARTAN POT TAB 100MG	36150040200340	1545368	1
MONTELUKAST TAB 10MG	44505050100330	1504018	2
FLUTICASONE SPR 50MCG	42200032301810	1457293	2
FUROSEMIDE TAB 40MG	37200030000310	1431104	1
HYDROCHLOROT TAB 25MG	37600040000305	1418147	1
LOSARTAN POT TAB 50MG	36150040200330	1380802	1
METOPROL TAR TAB 25MG	33200030100305	1373932	1
LISINOPRIL TAB 20MG	36100030000315	1330461	1
LISINOPRIL TAB 10MG	36100030000310	1289679	1
METFORMIN TAB 1000MG	27250050000350	1272210	1
METOPROL SUC TAB 50MG ER	33200030057520	1262627	2
LATANOPROST SOL 0.005%	86330050002020	1234098	2
LEVOTHYROXIN TAB 50MCG	28100010100310	1133973	1
TRAZODONE TAB 50MG	58120080100305	1130027	1
SIMVASTATIN TAB 20MG	39400075000330	1102347	1
HYDROCO/APAP TAB 10-325MG	65991702100305	1085558	2
HYDROCO/APAP TAB 5-325MG	65991702100356	1046024	2
GABAPENTIN CAP 100MG	72600030000110	1041837	2
ATORVASTATIN TAB 80MG	39400010100350	1015571	1
LEVOTHYROXIN TAB 75MCG	28100010100315	978405	1
FAMOTIDINE TAB 20MG	49200030000320	957675	2
MELOXICAM TAB 15MG	66100052000330	930884	1
LISINOPRIL TAB 40MG	36100030000330	897380	1
METFORMIN TAB 500MG ER	27250050007520	893209	1
SERTRALINE TAB 100MG	58160070100320	890462	1
ALBUTEROL AER HFA (VENTOLIN	44201010103410	881979	2
ALENDRONATE TAB 70MG	30042010100370	863346	1
LOSARTAN POT TAB 25MG	36150040200320	824332	1
SIMVASTATIN TAB 40MG	39400075000340	822560	1
FINASTERIDE TAB 5MG	56851030000320	819965	1
SERTRALINE TAB 50MG	58160070100310	785477	1
METOPROL TAR TAB 50MG	33200030100310	781725	1
ROSUVASTATIN TAB 10MG	39400060100310	764330	1
LISINOPRIL TAB 5MG	36100030000305	755923	1
AMOXICILLIN CAP 500MG	01200010100110	732827	1
LEVOTHYROXIN TAB 100MCG	28100010100320	728269	1
CEPHALEXIN CAP 500MG	02100020000110	720734	2
SPIRONOLACT TAB 25MG	37500020000305	712615	1

Label Name2	GPI 14 Strength Cod	Sum of Total Rx 2021	Tier
AZITHROMYCIN TAB 250MG	03400010000320	703872	2
DULOXETINE CAP 60MG	58180025106750	697898	2
ESCITALOPRAM TAB 10MG	58160034100320	688586	2
ROSUVASTATIN TAB 20MG	39400060100320	684534	1
TRAZODONE TAB 100MG	58120080100310	673055	1
DONEPEZIL TAB 10MG	62051025100320	672079	2
ALLOPURINOL TAB 100MG	68000010000305	666947	1
AMLODIPINE TAB 2.5MG	34000003100320	663567	1
LORAZEPAM TAB 0.5MG	57100060000305	662562	2
CLONAZEPAM TAB 0.5MG	72100010000305	661482	2
XARELTO TAB 20MG	83370060000340	656985	3
ELIQUIS TAB 2.5MG	83370010000320	654349	3
LEVOTHYROXIN TAB 25MCG	28100010100305	648312	1
ZOLPIDEM TAB 10MG	60204080100315	642912	2
BASAGLAR INJ 100UNIT	2710400300D220	640191	3
PRAVASTATIN TAB 40MG	39400065100340	609362	1
METOPROL SUC TAB 100MG ER	33200030057530	602276	2
ALPRAZOLAM TAB 0.5MG	57100010000310	581976	2
NOVOLOG INJ FLEXPEN	2710400200D220	575735	3
GABAPENTIN TAB 600MG	72600030000330	569596	2
MIRTAZAPINE TAB 15MG	58030050000315	553455	2
OXYCOD/APAP TAB 10-325MG	65990002200335	546911	2
TIZANIDINE TAB 4MG	75100090100320	540552	2
PREDNISONE TAB 20MG	22100045000325	537420	1
LORAZEPAM TAB 1MG	57100060000310	535196	2
ESCITALOPRAM TAB 20MG	58160034100330	532725	2
CARVEDILOL TAB 6.25MG	33300007000310	530767	1
EZETIMIBE TAB 10MG	39300030000320	527174	2
CITALOPRAM TAB 20MG	58160020100320	526731	1
CARVEDILOL TAB 12.5MG	33300007000320	522275	1
CARVEDILOL TAB 25MG	33300007000330	521555	1
POT CL MICRO TAB 20MEQ ER	79700030100440	519558	2
CLONAZEPAM TAB 1MG	72100010000310	518893	2
LEVOTHYROXIN TAB 88MCG	28100010100317	517105	1
AMOX/K CLAV TAB 875-125	01990002200340	513754	2
POT CHLORIDE TAB 10MEQ ER	79700030000430	510659	2
METHYLPRED TAB 4MG	2210003000B705	508747	2
HYDROCHLOROT TAB 12.5MG	37600040000303	508618	1
IBUPROFEN TAB 800MG	66100020000340	502292	2
HYDROCO/APAP TAB 7.5-325	65991702100358	496942	2
PREDNISONE TAB 10MG	22100045000320	494418	1
BACLOFEN TAB 10MG	75100010000305	494373	2
SYMBICORT AER 160-4.5	44209902413240	494116	3
CYCLOBENZAPR TAB 10MG	75100050100305	493798	2
FLUOXETINE CAP 20MG	58160040000120	493720	1
FAMOTIDINE TAB 40MG	49200030000340	491611	2

Health is personal.

2020 Annual Report

CVS Health®

Dear Fellow Stockholders:

In my first letter as president and chief executive officer, let me begin by expressing how honored I am to lead this great company and our dedicated team of nearly 300,000 CVS Health colleagues as we work together to reimagine health care. During one of the most challenging years in our nation's history, our purpose to help people on their path to better health has never been more important. Since the pandemic struck, CVS Health colleagues served a prominent role in supporting our customers, providers, and communities, while we outperformed on our financial commitments.

Over the past decade, we have been on a journey to become the nation's leading diversified health services company. As one of the most trusted brands in America, our presence in communities across the country allows us to meet consumers where they are and support them for every meaningful moment of health throughout their lifetime.

Karen S. Lynch
President and Chief Executive Officer

Continued growth in our core businesses drove our strong performance in 2020

In 2020, CVS Health year-over-year total revenues grew by 5 percent to $268.7 billion. GAAP diluted earnings per share (EPS) from continuing operations grew by 8 percent to $5.47 and Adjusted EPS grew by 6 percent to $7.50*. We achieved over $900 million of integration synergies and generated $15.9 billion in cash flow from operations, which we deployed to invest in our future, maintain our quarterly dividend, and reduce debt. In total, we have repaid over $12.2 billion in net debt since the close of the Aetna transaction. We remain on track to achieve our target leverage ratio in 2022 and are committed to returning value to our stockholders.

Our strong results demonstrate that our strategy and business model are working.

- In the Health Care Benefits segment, we grew total revenue by 8 percent for the year, with strong growth coming from our Government businesses.
- Our Pharmacy Services segment has been resilient throughout the pandemic. We demonstrated the value we bring to our customers and members, achieving strong retention rates and positive momentum in winning new business.
- In our Retail/Long-Term Care segment, we continued to advance our clinical programs that improve medication adherence and health outcomes. We increased the level of engagement with our loyalty and subscription customers, achieving high customer satisfaction results.

Delivered new solutions and established an unparalleled response to COVID-19

During the past year, we delivered new market solutions and strengthened our role as a trusted health care partner in response to COVID-19.

We rapidly innovated to meet customer needs for COVID-19 testing in the community. Today, we remain the largest community testing organization in the United States. Through our fourth quarter earnings call, we had administered approximately 15 million tests at our more than 4,800 testing locations nationwide. Over 50 percent of these tests were administered in communities with significant need for support, according to the CDC Social Vulnerability Index. Additionally, we launched our Return Ready℠ solution to help employers and universities as they execute their return-to-work and school strategies. Such leadership enabled us to establish new relationships with approximately 8 million consumers who previously were not CVS Health customers.

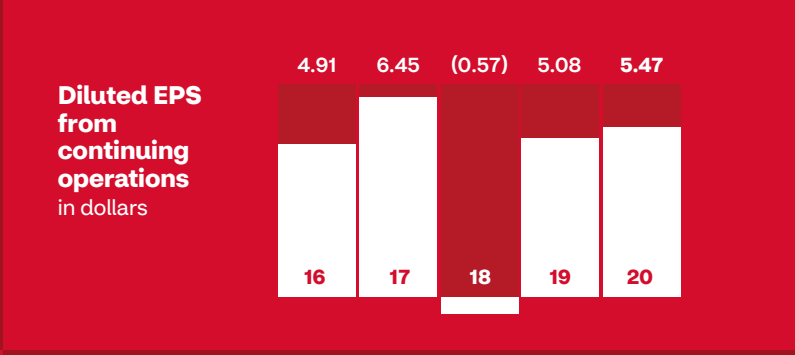
We started working with the federal government on vaccine distribution readiness in the fourth quarter of 2020 and were selected as one of the partners for vaccine administration in long-term care facilities. We administered more than 4 million vaccine doses to patients and staff in over 40,000 long-term care facilities across the country through the end of February. We were also selected as one of the national partners for the Federal Pharmacy Partnership program through which we administer COVID-19 immunizations in our CVS Pharmacy locations. With the commitment and hard work of our employees, we have the capacity to administer 20 to 25 million doses per month, depending on availability.

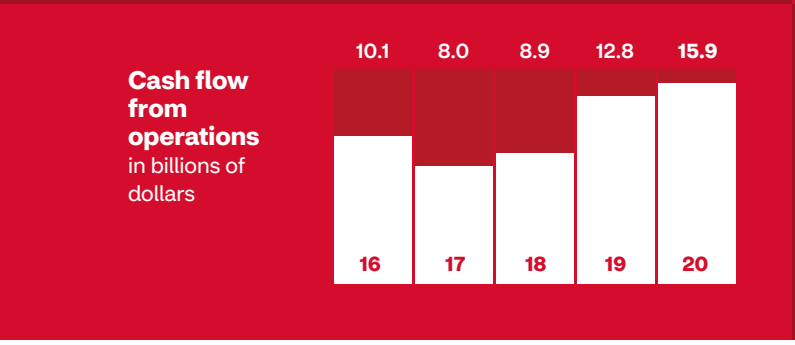
I am grateful for our colleagues, particularly those on the front lines, who worked tirelessly to help millions of Americans through extraordinary circumstances and all that we have achieved this past year.

Making significant progress in creating new CVS Health services and integrated value

We have made measurable and important progress with our strategy as a health services company that integrates and utilizes all our assets to create a superior customer experience that firmly addresses the total cost of care.

- We are creating health platforms that combine local points of care, remote monitoring, virtual care, and access to health care professionals – all within a personalized consumer-centric model. Examples of these new programs include Transform Diabetes Care®, Transform Oncology Care®, and the CVS Kidney Care® program.
- We have seen strong reception to our first fully integrated plan, the Aetna Connected Plan®, and expect to make this plan available in an additional 15 markets in 2021. Key features include zero-dollar copays at MinuteClinic® locations**, standard formulary, and use of the CVS Health Coram® infusion services.





- We have deepened our pharmacy penetration into the Health Care Benefits segment through increased cross-selling of medical and pharmacy plans. This is expected to result in approximately $350 million in incremental revenue in 2021.
- We launched new medical benefit plans designed with low-copay or no-copay at MinuteClinics to offer broader access to care. We have approximately 6 million Aetna Commercial and Medicare members enrolled to date.
- We ended 2020 with just over 650 HealthHUB® locations nationwide, including locations in underserved communities. The HealthHUB is one of the many channels we have to engage with consumers for their health, that also improve access to quality and holistic care.
- We continue to expand our virtual care capabilities with our E-Clinic service in our MinuteClinic footprint and our virtual-first primary care program where members can engage with providers virtually.

These examples clearly show that we are delivering value by creating superior health offerings that help consumers get quality, affordable, and convenient care.

Deepening our commitment to Corporate Social Responsibility

In addition to spearheading initiatives related to COVID-19, we furthered our leadership in sustainability and corporate social responsibility. For the second straight year, CVS Health was named in the prestigious Dow Jones Sustainability World Index. We renewed and strengthened our commitment to addressing the racial health disparities and social injustices that weaken our nation and affect health. Over the next five years, we are investing nearly $600 million to advance employee, community, and public policy initiatives that address inequality faced by Black Americans and other underserved communities. In 2020 we also made great strides in advancing a holistic strategic diversity management strategy that supports our business objectives and creates new opportunities for our colleagues. Diversity powers our ability to support patients and customers with empathy, respect, and cultural sensitivity, helping to build healthier communities. Our workforce development programs support our efforts to cultivate and recruit the best health care talent in the country.

We took steps to address diversity among our senior leadership and worked to develop benchmarks and measure outcomes in diverse representation at all levels of our organization. For the first time, we've tied performance in this area to executive compensation.

You can read about our activities on pages 7–8. For a comprehensive overview, read the *CVS Health 2020 Corporate Social Responsibility Report* on our corporate website.

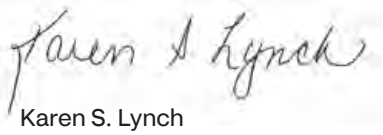
Strong momentum for 2021 and beyond

In summary, we are starting 2021 with strong momentum. We are accelerating our pace of progress to drive our consumer-centric strategy – a strategy built upon the fundamental belief that solving consumer health needs will create value for our customers, our communities, and our stockholders.

I want to thank Larry Merlo and the Board of Directors for setting a bold path for CVS Health to change health care in this country. Larry did an incredible job of bringing together our unique assets and establishing the foundation for our future. You can read more about Larry's achievements on page 9, where he also shares a few parting thoughts.

I am confident in our future and in our ability to help people on their path to better health. On behalf of the Board and our colleagues, thank you for investing in CVS Health.

Sincerely,



Karen S. Lynch
President and Chief Executive Officer
April 2, 2021

* Adjusted EPS is a non-GAAP financial measure. A reconciliation of GAAP diluted EPS from continuing operations to Adjusted EPS is provided under the heading "Reconciliation" in the back pages of this Annual Report.

** Not applicable to HSA plans

Health is personal.

CVS Health is committed to addressing the unique, holistic health care needs of each of our customers. We are engaging them in ways that address the most prevalent, costly, and complex health conditions impacting their lives. As a result, we can drive better health outcomes, improving their experience, enhancing access, making care more affordable, and being their trusted health care partners for every meaningful moment of health in their lives. Over the next few pages, learn how we are achieving the following: demonstrating the integrated value of our unique portfolio of products and services; enhancing the consumer experience through digital services that seamlessly connect to in-person channels; and expanding innovative, consumer-oriented solutions. All the while, we continue to build a high-performing organization that is passionate about our purpose, reflects the diverse populations we serve, and is empowered to do the right thing for our consumers' health and wellbeing.

Integrated Value | Demonstrating the value of our products and services

CVS Health is creating unmatched products for today's health care consumers. For plan members as well as anyone walking through the doors of our community touchpoints, our integrated solutions are helping to lower costs and improve outcomes.

- CVS HealthHUB locations provide customers with a convenient and compelling destination for managing their health. These specialized CVS stores provide access to a variety of services, including health services for both everyday and acute care needs, personalized support for certain chronic health conditions, and pharmacy programs to improve adherence.
- Approximately 6 million Commercial and Medicare members are enrolled in a newly launched integrated plan with low-copay or no-copay at our approximately 1,100 MinuteClinics. Small Group members, who were first to adopt this benefit, are using MinuteClinics 25 percent more frequently. As a result, customers are seeing significant cost savings.
- Our HealthHUB and MinuteClinic locations are key components of the recently introduced Aetna Connected Plan. In addition to zero-dollar copays at MinuteClinics for non-HSA plans, plan members benefit from competitive premiums, virtual care, use of Coram infusion services, and a standard medication formulary with 1- to 2-day prescription delivery.

Retail pharmacies
MinuteClinic
HealthHUB
Provider network
Health and wellness management
Front store loyalty and rewards
Total store delivery and fulfillment
Local senior care team
Digital tools and services
Coram infusion services

Aetna Connected Plan

- First-of-its-kind health care benefits program
- Utilizes broad range of assets to provide comprehensive health services and affordability

Subscription Program

- Provides members with free 1- to 2-day delivery on front store items and free prescription delivery on eligible prescriptions
- Offers access to 24/7 pharmacist helpline
- Features a 20 percent discount on eligible CVS Health® brand products

Medicare Resource Center

- Provides helpful support to enroll customers in Aetna or non-Aetna plans alike
- Introduces customers to all services our community locations have to offer

Creating more opportunities to engage with new customers and turn them into loyal ones

~4 million subscription program customers, yielding 25% higher sales*
* relative to other customers

>100 million members supported through our benefit offerings

~8 million new customers to CVS Health through COVID-19 testing

>74 million active ExtraCare® members

Unless otherwise specified, metrics are as of fourth quarter earnings call, February 16, 2021

Innovation | Expanding our consumer-oriented solutions

CVS Health has long been an industry leader with innovations that close gaps in care and drive greater adherence. Our latest offerings reflect the breadth of our integrated capabilities and the importance of addressing unmet needs among patients with chronic conditions.

- Our next-generation Transform Diabetes Care program combines local points of care, remote biometric monitoring, and access to health care professionals – all within a consumer-centric model that provides personalized guidance and resources.
- CVS Health is bringing dialysis services into the home to better manage chronic kidney disease (CKD). This is part of our CKD management program, which offers a simpler, more patient-centric approach to help delay the onset of end-stage renal disease, reduce hospital admissions, and support people with treatment options.
- The Transform Oncology Care program helps cancer patients start on the best treatment and matches eligible patients to clinical trials. We strive to improve patient outcomes and lower overall costs at every point of the care journey.

Clinical programs that make a difference

We advanced several integrated health management programs this past year in the areas of diabetes, kidney care, and oncology

Next-generation diabetes program

~1.4 million
customers

Expanding chronic kidney disease care management

Currently available to
>7.5 million
eligible members

Oncology care program expanding to cover more patients

125+
provider systems across 28 states

Convenience, simplicity, and personalization

MinuteClinics at our HealthHUB locations serve a variety of health needs, from everyday and acute care needs to personalized health management programs for those with certain chronic health conditions

- Diabetes and other chronic conditions
- Preventative care and wellness
- Blood pressure screening and management
- Age 12+ immunizations
- Sleep assessments
- Acute care
- School and sports physicals

Unless otherwise specified, metrics are as of fourth quarter earnings call, February 16, 2021

Digital Services | Enhancing the consumer experience

Today's savvy health care consumers demand more flexibility in their interactions with providers. Virtual care can offer a convenient and lower-cost alternative and direct consumers to in-person visits when appropriate.

- In the midst of a pandemic, the ability to access care from the safety of one's home has never been more important. MinuteClinic has been providing a direct-to-consumer telehealth solution since 2018, and today provides comprehensive virtual care in 46 states plus the District of Columbia. That includes diagnosis and treatment of common injuries, behavioral health services, and the management of chronic conditions.
- In 2021, Aetna launched our virtual-first primary care program. Participating members can engage with providers online first and are then directed to lower-cost, high-quality sites of care or other effective in-network care settings as needed.
- Our Caremark members can interact with us on their own terms, with more than 80 percent of our Specialty Pharmacy members opting into our digital programs. Furthermore, our members can pick up medications locally or have them delivered directly to their homes.

Significant rise in virtual care utilization

Consumer preferences are increasingly turning towards solutions characterized by greater convenience, simplicity, personalization, and on-demand access

MinuteClinic provides comprehensive virtual care in 46 states and D.C.

Aetna launched virtual-first primary care program

Consumer surveys show >50% of respondents are open to using virtual care after the pandemic ends

Unless otherwise specified, metrics are as of fourth quarter earnings call, February 16, 2021

Committed to corporate social responsibility

2020 was a year unlike any other. In the face of incredible challenges, CVS Health emerged a stronger, more resilient company, better positioned to meet the health care needs of our customers. Throughout the challenges we have faced, we have demonstrated the deep impact we can have on people's health care journeys as a combined enterprise. Our Corporate Social Responsibility (CSR) strategy is integral to how CVS Health delivers on our purpose. Centered on the four priority areas below, *Transform Health 2030* is our vision for how we can build a better, healthier world. We've developed big, bold goals that will help us deliver on this strategy. We continue to advance our commitments to build healthier communities and support their economic health, mitigate our environmental impacts, and foster the growth and development of our colleagues.

Healthy People

We're delivering on our purpose of helping people on their path to better health across all touch points. To truly improve health outcomes, we need to be innovative and connect with people where they are – online, in their homes, at work, and in their neighborhoods and communities.

Healthy Business

We are committed to fostering a business that creates value for our colleagues, stockholders, partners, and supply chains. Our role as one of the nation's largest employers – and a leader among the *Fortune 500* – provides us with an exceptional opportunity to drive economic growth through job creation and across our supply chain. We are committed to operating a healthy business for all our stakeholders.

Healthy Planet

The health of our environment is inextricably linked to human health, and we are committed to doing our part as a health care leader. We believe we have a responsibility as a leader in health care to help transform the health of our planet, just as we help people on their path to better health.

Healthy Community

We are delivering significant social impacts to support the health of communities across the United States and improve health outcomes in the communities we serve. By working with other organizations and through innovative programs that can be executed in a variety of communities, we are driving positive health outcomes and reducing overall costs.

Investing in a tobacco-free generation

15 million+
youth reached through education, awareness advocacy, and healthy behavior programming

36%
decline in new youth smokers since 2016

$55 million
invested from 2016 through 2021 to help people lead tobacco-free lives

Focused on a future of equity

Nearly
$600 million
earmarked over next five years to address racial inequity, including **$5 million** scholarship program for Black and Latinx students

Caring for our colleagues

15,000+
colleagues received dependent care assistance

$2.5 million+
in grants provided to colleagues by Employee Relief Fund

Bringing testing to local communities

The world changed in 2020. At CVS Health, we met these changes with accelerated innovation to better serve our customers, patients, and partners. By the end of the year, we had administered over 10 million COVID-19 tests at more than 4,000 CVS Pharmacy locations, and in collaboration with community health organizations, employers, and long-term care facilities. We also made rapid-result testing available through Return Ready, CVS Health's comprehensive COVID-19 testing solution for employers and universities. By the end of 2020, Return Ready had administered more than 265,000 tests across 113 unique testing locations. In October, we announced plans to hire 15,000 new colleagues to bolster our COVID-19 response, with more than 10,000 of these new roles for licensed pharmacy technicians at CVS Pharmacy locations.

Advancing diversity, equity, inclusion, and justice

CVS Health saw tragic injustices unfold in our communities in 2020 due to systemic racism. Building on our best-in-class diversity management strategy, we renewed our focus on advancing social justice and health equity and announced significant new commitments – to our colleagues, our customers, and our communities. Over the next five years, we are investing nearly $600 million to advance employee, community, and public policy initiatives that address the inequity faced by Black people and other marginalized communities. For example, the CVS Health Foundation established a five-year, $5 million scholarship program for Black and Latinx students in collaboration with the UNCF (formerly known as the United Negro College Fund).

Supporting community health

In 2020, we prioritized supporting those most significantly impacted by the COVID-19 pandemic. By building on longstanding relationships with trusted local organizations, we delivered resources – including critical access to diagnostic testing – to the most at-risk populations. We also supported continuation of care to manage chronic conditions and provided access to healthy food. Working with national and local organizations, we improved access to housing, food security, and education as well. Despite the challenges presented by COVID-19, we also maintained our commitment to help deliver the nation's first tobacco-free generation and contributed to a 36 percent decline in new youth smokers since 2016.

Reducing our impacts

The Carbon Disclosure Project recently named CVS Health to its A-list for climate change. We believe that the health of our planet is inextricably linked to the health of all people, and there continues to be a strain on our ecosystem and natural resources. As a leading health care company, we know that mitigating our impact on the environment can help us to be part of the solution – in combating climate change, achieving cleaner air and water, and preserving a healthier and more equitable environment for future generations.

10 million+
COVID-19 tests administered

4,000+
COVID-19 testing locations

Larry Merlo retired as President and Chief Executive Officer in February 2021, having led the company since 2011. Mr. Merlo leaves the Board of Directors in May. He joined what was then CVS Pharmacy in 1990 following the acquisition of Peoples Drug and held positions of increasing responsibility over the next three decades. Mr. Merlo played a leading role in integrating multiple acquisitions, including two transformational deals reshaping CVS as a diversified health services company: our purchases of Caremark in 2007 and Aetna in 2018. He leaves a company that recorded $268.7 billion in total revenues in 2020, placing us at No. 5 on the Fortune 500.

Dear Fellow Stockholders:

It has been an honor and a privilege to lead CVS Health and to have played a part in transforming health care in our country. We have accomplished a great deal and have many initiatives underway designed to improve health outcomes, enhance access, and lower costs. They include new plan designs with integrated offerings such as our HealthHUB services, chronic care management programs, and access to virtual care.

When I took on the role of CEO 10 years ago, my overarching objective was to transform CVS Health into a new kind of diversified health services company. We needed to migrate away from a successful but traditional pharmacy organization to an innovative enterprise that could integrate that successful pharmacy franchise into the broader and larger health care spectrum. As part of our robust strategy to achieve that objective, we accomplished the following:

- Drove tremendous growth in CVS Caremark to become the nation's leading pharmacy benefits manager;
- Invested in high-growth areas of specialty pharmacy, adding businesses such as Coram infusion services and NovoLogix®;
- Rebranded the enterprise as CVS Health and took bold actions that reinforced our purpose, including removing all tobacco products from our stores;
- Made health care easily accessible through our MinuteClinic and HealthHUB locations;
- Enhanced our retail footprint with the acquisition of Target pharmacies, while broadening our local appeal with the creation of the CVS Pharmacy y Más® format; and
- Strengthened our suite of assets with the industry-disrupting acquisition of Aetna.

Today, with an expansive physical presence in communities across the nation, CVS Health has the unmatched ability to meet customers where they are, and provide the care and services they need, be it in person or with the unique virtual delivery service capabilities that extend the company's physical presence in real time. That's what I'm most proud of: today, CVS Health is more than a corner drug store. It's a diversified health services company serving the needs of more than 100 million Americans each year.

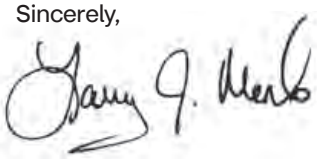
I'm delighted that the Board appointed Karen Lynch to succeed me. Karen is a seasoned executive with over 30 years of health care experience – the last eight with Aetna. She brings a relentless focus on the customer, a deep understanding of how to drive value across our integrated health care assets, and extensive experience in both strategy and operations. Karen has been an invaluable partner to me in the planning and execution of our transformation over the last two-plus years, and her experience and vision will be critical in driving CVS Health forward. Your investment couldn't be in better hands.

When I filled my first prescription as a newly licensed pharmacist in 1978, I could not have imagined the opportunities – and challenges – that awaited me. I have many to thank for my success. I want to acknowledge the CVS Health Board of Directors for its unwavering support throughout my tenure. As I leave the Board in May, I will be watching from the sidelines and cheering on the company's continued progress.

I also want to offer a heartfelt thank you to the nearly 300,000 CVS Health colleagues who have represented our company so enthusiastically. Without them, our success and growth would not have been possible. Their efforts have never been more impressive than over the past 12 months in the face of the pandemic. Our colleagues demonstrated their commitment to our purpose along with their capabilities in executing our strategy, leading the way for advancing care.

I wish you all good health in 2021 and for many years to come.

Sincerely,



Larry J. Merlo

April 2, 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, 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

CVSHealth

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	☐
Non-accelerated filer	☐	Smaller reporting company	☐
		Emerging growth company	☐

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

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

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 $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.

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.

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.

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:

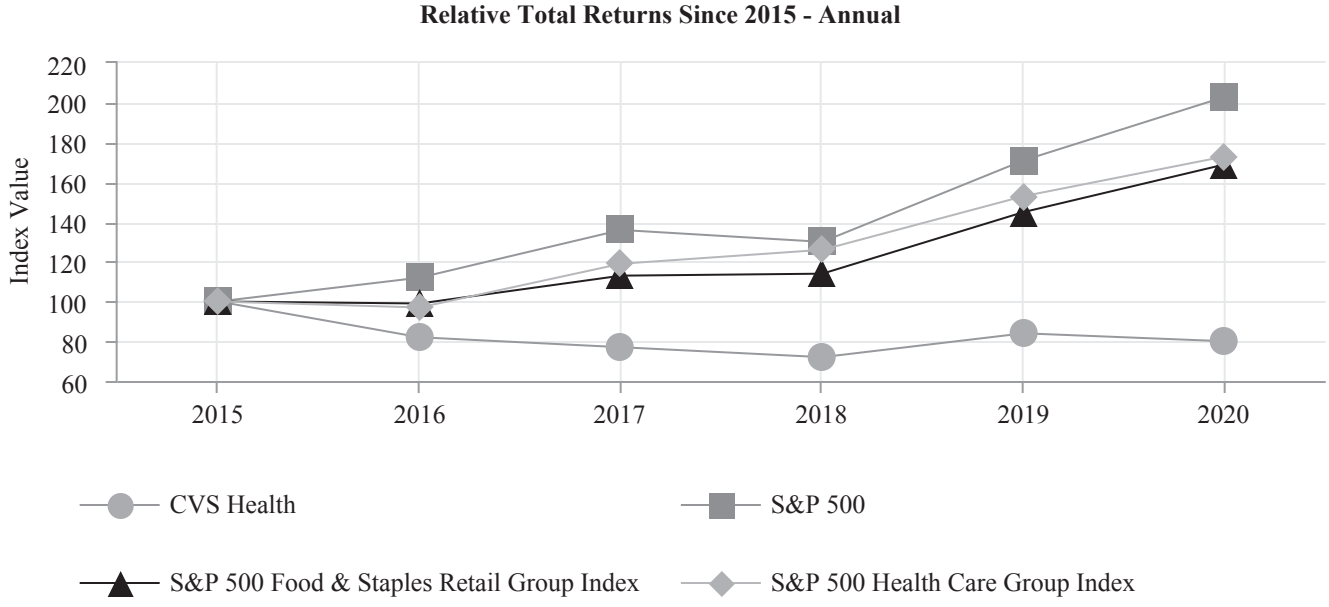
In billions			Remaining as of
Authorization Date		Authorized	December 31, 2020
November 2, 2016 ("2016 Repurchase Program")	$	15.0	$ 13.9

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 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.



	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.

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:

	Year Ended December 31,			Change 2020 vs. 2019		Change 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:

	Year Ended December 31,			Change			
				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.

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. 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.

Index to Consolidated Financial Statements

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.

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.

Consolidated Statements of Shareholders' Equity

In millions	Number of shares outstanding		Attributable to CVS Health						
	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:

In millions	Carrying Value	Estimated Fair 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
Less:		
Current portion of long-term debt	(5,440)	(3,781)
Long-term debt	$ 59,207	$ 64,699

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.

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

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.

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	
21.1	**Subsidiaries of the registrant** Subsidiaries of CVS Health Corporation.
23	
23.1	**Consents of experts and counsel** Consent of Ernst & Young LLP.
31	
31.1	**Rule 13a-14(a)/15d-14(a) Certifications**
31.2	Certification by the Chief Executive Officer. Certification by the Chief Financial Officer.
32	
32.1	**Section 1350 Certifications**
32.2	Certification by the Chief Executive Officer. Certification by the Chief Financial Officer.
101	
101	**Interactive Data File** 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.

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

Reconciliation

Adjusted Earnings Per Share (Unaudited)

CVS Health uses non-GAAP financial measures to analyze underlying business performance and trends. CVS Health believes that providing these non-GAAP financial measures enhances CVS Health's and investors' ability to compare CVS Health's past financial performance with its current performance. These non-GAAP financial measures are provided as supplemental information to the financial measures CVS Health discloses that are calculated and presented in accordance with GAAP. Non-GAAP financial measures should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP. CVS Health's definitions of its non-GAAP financial measures may not be comparable to similarly titled measurements reported by other companies.

CVS Health defines adjusted income from continuing operations attributable to CVS Health as income (loss) from continuing operations attributable to CVS Health (GAAP measure) excluding the impact of amortization of intangible assets and other items, if any, that neither relate to the ordinary course CVS Health's business nor reflect CVS Health's underlying business performance, such as acquisition-related transaction and integration costs, gains/losses on divestitures, income associated with the receipt of fully reserved amounts owed to CVS Health under the ACA risk corridor program, store rationalization charges, losses on early extinguishment of debt, goodwill impairments, impairment of long-lived assets, losses on settlements of defined benefit pension plans, adjustments to legal reserves in connection with legal settlements, net interest expense on financings associated with proposed acquisitions (for periods prior to the acquisition), the corresponding tax benefit or expense related to the items excluded from adjusted income from continuing operations attributable to CVS Health, the corresponding impact to income allocable to participating securities, net of tax, related to the items excluded from income from continuing operations attributable to CVS Health in determining adjusted income from continuing operations attributable to CVS Health, and any other items specifically identified herein. GAAP diluted EPS from continuing operations and Adjusted EPS, respectively, are calculated by dividing income (loss) from continuing operations attributable to CVS Health and adjusted income from continuing operations attributable to CVS Health by CVS Health's weighted average diluted shares outstanding.

The following are reconciliations of income (loss) from continuing operations attributable to CVS Health to adjusted income from continuing operations attributable to CVS Health and calculations of GAAP diluted EPS from continuing operations and Adjusted EPS:

	Year Ended December 31,				
In millions, except per share data	**2020**	**2019**	**2018**	**2017**	**2016**
Income (loss) from continuing operations (GAAP measure)	$ 7,201	$ 6,631	$ (596)	$ 6,631	$ 5,320
Net loss (income) attributable to noncontrolling interests (GAAP measure)	(13)	3	2	(1)	(2)
Income allocable to participating securities (GAAP measure)	—	(5)	(3)	(24)	(27)
Income (loss) from continuing operations attributable to CVS Health (GAAP measure)	7,188	6,629	(597)	6,606	5,291
Non-GAAP adjustments:					
Amortization of intangible assets [(1)]	2,341	2,436	1,006	817	795
Acquisition-related transaction and integration costs [(2)]	332	480	492	65	291
(Gain) loss on divestiture of subsidiary [(3)]	(269)	205	86	9	—
Receipt of fully reserved ACA risk corridor receivable [(4)]	(307)	—	—	—	—
Store rationalization charges [(5)]	—	231	—	215	34
Loss on early extinguishment of debt [(6)]	1,440	79	—	—	643
Goodwill impairments [(7)]	—	—	6,149	181	—
Impairment of long-lived asset [(8)]	—	—	43	—	—
Losses on settlements of defined benefit pension plans [(9)]	—	—	—	187	—
Adjustments to legal reserves in connection with legal settlements [(10)]	—	—	—	—	(85)
Net interest expense on financing activities [(11)]	—	—	894	56	—
Tax impact of non-GAAP adjustments [(12)]	(877)	(815)	(658)	(2,096)	(665)
Receipt of fully reserved ACA risk corridor receivables attributable to noncontrolling interest, net of tax [(4)]	12	—	—	—	—
Income allocable to participating securities, net of tax [(13)]	—	(1)	(9)	2	(4)
Adjusted income from continuing operations attributable to CVS Health	$ 9,860	$ 9,244	$ 7,406	$ 6,042	$ 6,300
Weighted average diluted shares outstanding (GAAP)	1,314	1,305	1,044	1,024	1,079
Adjusted weighted average diluted shares outstanding (non-GAAP) [(14)]	1,314	1,305	1,047	1,024	1,079
GAAP diluted earnings per share from continuing operations	$ 5.47	$ 5.08	$ (0.57)	$ 6.45	$ 4.91
Adjusted EPS	$ 7.50	$ 7.08	$ 7.08	$ 5.90	$ 5.84

Footnotes

1) CVS Health's and its subsidiaries' (collectively 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 condensed 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 and 2019, acquisition-related transaction and integration costs relate to the acquisition (the "Aetna Acquisition") of Aetna Inc. ("Aetna"). In 2018 and 2017, acquisition-related transaction and integration costs relate to the Aetna Acquisition and the acquisition of Omnicare, Inc ("Omnicare"). In 2016, acquisition-related integration costs relate to the acquisition of Omnicare and the pharmacies and clinics of Target.
3) In 2020, the gain on divestiture of subsidiary represents the pre-tax gain on the sale of the Workers' Compensation business, which was sold on July 31, 2020 for approximately $850 million. In 2019, the loss on divestiture of subsidiary represents the pre-tax loss on the sale of the Company's Brazilian subsidiary, Drogaria Onofre Ltda. ("Onofre"), which occurred on July 1, 2019, and 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 ("RxCrossroads") for $725 million on January 2, 2018. In 2017, the loss on divestiture of subsidiary represents transaction costs associated with the sale of RxCrossroads.
4) In 2020, the Company received $313 million owed to it under the Patient Protection and Affordable Care Act and the Health Care Education Reconciliation Act of 2010 (collectively, the "ACA") 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 rebate requirements and premium taxes, the Company recognized pre-tax income of $307 million. The portion of the ACA risk corridor payment attributable to noncontrolling interest was $12 million related to third party ownership interests in the Company's consolidated operating entities.
5) In 2019, the store rationalization charges relate to the planned closure of 22 underperforming retail pharmacy stores in the first quarter of 2020 and the planned closure of 46 underperforming retail pharmacy stores in the second quarter of 2019. These store rationalization charges primarily relate to operating lease right-of-use asset impairment charges. In 2017 and 2016, the store rationalization charges primarily represent charges for noncancelable lease obligations associated with stores closed in connection with the Company's enterprise streamlining initiative.
6) In 2020, the loss on early extinguishment of debt related to the Company's repayment of $4.5 billion of its outstanding senior notes in December 2020 pursuant to its tender offers for such senior notes and the Company's repayment of $6.0 billion of its outstanding senior notes in August 2020 pursuant to its tender offers for such senior notes. In 2019, the loss on early extinguishment of debt related to the Company's repayment of $4.0 billion of its outstanding senior notes in August 2019 pursuant to its tender offers for such senior notes. In 2016, the loss on early extinguishment of debt related to the Company's repayment of $4.2 billion of its outstanding senior notes pursuant to its tender offer for such senior notes.
7) 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.

8) In 2018, impairment of long-lived assets primarily relates to the impairment of property and equipment within the Retail/LTC segment.
9) In 2017, the Company settled the pension obligations of its two tax-qualified 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 the pension plan assets, resulted in pre-tax settlement losses related to the recognition of accumulated deferred actuarial losses.
10) In 2016, adjustments to legal reserves represent legal charges of $3 million in the first quarter of 2016 in connection with a disputed 1999 legal settlement and an $88 million reversal of an accrual in connection with a legal settlement in the fourth quarter of 2016. In 2015, adjustments to legal reserves include a charge related to a legacy lawsuit challenging the 1999 legal settlement by MedPartners of various securities class actions and a related derivative claim.
11) In 2018, net interest expense on financing activities includes interest expense related to (i) bridge financing costs, (ii) interest expense on $40 billion of unsecured senior notes issued on March 9, 2018 (the “2018 Notes”) and (iii) interest expense on the Company’s $5 billion term loan facility relating to the Aetna Acquisition. The interest expense was reduced by related interest income earned on the proceeds of the 2018 Notes. All amounts are for the periods prior to the close of the Aetna Acquisition, which occurred on November 28, 2018. In 2017, net interest expense on financing activities includes bridge financing costs related to the Aetna Acquisition.
12) Represents the corresponding tax benefit or expense related to the items excluded from adjusted income from continuing operations attributable to CVS Health and Adjusted EPS above. The nature of each non-GAAP adjustment is evaluated to determine whether a discrete adjustment should be made to the adjusted income tax provision.
13) Represents the corresponding impact to income allocable to participating securities, net of tax, related to the items above excluded from income (loss) from continuing operations attributable to CVS Health in determining adjusted income from continuing operations attributable to CVS Health and calculating Adjusted EPS above.
14) Adjusted EPS for the year ended December 31, 2018 is calculated utilizing adjusted weighted average diluted shares outstanding, which includes 3 million potential common equivalent shares, as the impact of these shares was dilutive. The potential common equivalent shares were excluded from the calculation of GAAP loss per share from continuing operations for the year ended December 31, 2018, as the shares would have had an anti-dilutive effect as a result of the GAAP net loss incurred.

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Officer, Director, and Stockholder Information

Officers

Karen S. Lynch
President and Chief Executive Officer

Eva C. Boratto
Executive Vice President and Chief Financial Officer

Jonathan C. Roberts
Executive Vice President and Chief Operating Officer

Troyen A. Brennan, M.D.
Executive Vice President and Chief Medical Officer

David A. Falkowski
Executive Vice President and Chief Compliance Officer

Daniel P. Finke
Executive Vice President and President – Health Care Benefits

Joshua M. Flum
Executive Vice President – Enterprise Strategy

Laurie P. Havanec
Executive Vice President and Chief People Officer

Alan M. Lotvin, M.D.
Executive Vice President and President – Pharmacy Services

Neela Montgomery
Executive Vice President and President – Retail

Thomas M. Moriarty
Executive Vice President, Chief Policy and External Affairs Officer and General Counsel

Michelle A. Peluso
Executive Vice President and Chief Customer Officer

Eileen Howard Boone
Senior Vice President, CSR and Philanthropy and Chief Sustainability Officer

David L. Casey
Senior Vice President and Chief Diversity Officer

James D. Clark
Senior Vice President – Controller and Chief Accounting Officer

Carol A. DeNale
Senior Vice President and Treasurer

John P. Kennedy
Senior Vice President and Chief Tax Officer

Colleen M. McIntosh
Senior Vice President, Secretary, Chief Governance Officer and Assistant General Counsel

Thomas S. Moffatt
Vice President, Asst. Secretary and Asst. General Counsel – Corporate Services

OFFICERS' CERTIFICATIONS
The Company has filed the required certifications under Section 302 of the Sarbanes-Oxley Act of 2002 regarding the quality of our public disclosures as Exhibits 31.1 and 31.2 to our Annual Report on Form 10-K for the fiscal year ended December 31, 2020. After our 2020 annual meeting of stockholders, the Company filed with the New York Stock Exchange the CEO certification regarding its compliance with the NYSE corporate governance listing standards as required by NYSE Rule 303A.12(a).

Directors

Fernando Aguirre (1) (5)
Former Chairman and Chief Executive Officer, Chiquita Brands International, Inc.

C. David Brown II (3) (5) (6)
Partner and Member of the Executive Committee, Nelson Mullins Riley & Scarborough

Alecia A. DeCoudreaux (1) (4)
President Emerita, Mills College and Former Executive, Eli Lilly and Company

Nancy-Ann M. DeParle (4) (5) (6)
Managing Partner and Co-Founder, Consonance Capital Partners, LLC and Former Deputy Chief of Staff and Director of the White House Office of Health Reform

David W. Dorman (3) (5) (6)
Chair of the Board, CVS Health Corporation and Former Chairman and CEO, AT&T Corporation

Roger N. Farah (3) (4)
Former Chairman of the Board, Tiffany & Co. and Former Executive, Tory Burch and Ralph Lauren

Anne M. Finucane (2) (3) (6)
Vice Chairman and Member of Executive Management Team, Bank of America Corporation

Edward J. Ludwig (1) (2) (6)
Former Chairman and Chief Executive Officer, Becton, Dickinson and Company

Karen S. Lynch (6)
President and Chief Executive Officer, CVS Health Corporation

Larry J. Merlo
Strategic Advisor; Former President and Chief Executive Officer, CVS Health Corporation

Jean-Pierre Millon (1) (4)
Former President and Chief Executive Officer, PCS Health Systems, Inc.

Mary L. Schapiro (1) (2)
Vice Chair for Public Policy and Special Advisor to the Founder and Chairman, Bloomberg L.P., and Former Chairman of the U.S. Securities and Exchange Commission

William C. Weldon (3) (5)
Former Chairman and Chief Executive Officer, Johnson & Johnson

Tony L. White (3) (4) (6)
Former Chairman, President and Chief Executive Officer, Applied Biosystems, Inc.

(1) Audit Committee
(2) Investment and Finance Committee
(3) Management Planning and Development Committee
(4) Medical Affairs Committee
(5) Nominating and Corporate Governance Committee
(6) Executive Committee

Stockholder Information

Corporate Headquarters
CVS Health Corporation
One CVS Drive, Woonsocket, RI 02895
(401) 765-1500

Annual Stockholders' Meeting
May 13, 2021
www.virtualshareholdermeeting.com/CVS2021

Stock Market Listing
The New York Stock Exchange
Symbol: CVS

Transfer Agent and Registrar
Questions regarding stock holdings, certificate replacement/transfer, dividends and address changes should be directed to:

EQ Shareowner Services
P.O. Box 64874
St. Paul, MN 55164-0874
Toll-free: (877) CVS-PLAN (287-7526)
International: +1 (651) 450-4064
Email: stocktransfer@eq-us.com
Website: www.shareowneronline.com

Direct Stock Purchase/Dividend Reinvestment Program
Shareowner Services Plus Plan℠ provides a convenient and economical way for you to purchase your first shares or additional shares of CVS Health common stock. The program is sponsored and administered by EQ Shareowner Services. For more information, including an enrollment form, please contact EQ Shareowner Services at (877) 287-7526.

Annual Report on Form 10-K and Other Company Information
The Company's Annual Report on Form 10-K will be sent without charge to any stockholder upon request by contacting:

CVS Health Corporation
Investor Relations Office
One CVS Drive, MC 1008
Woonsocket, RI 02895
(800) 201-0938

In addition, financial reports and recent filings with the Securities and Exchange Commission, including our Form 10-K, as well as other Company information, are available via the Internet at investors.cvshealth.com.

designed and produced by **see see eye**

There for every meaningful moment in health.

Trees Saved	Water Saved	Energy Saved	Greenhouse Gases Not Produced	Hazardous Air Pollutants Not Produced
243 fully grown	**59,382 gallons**	**962 MM BTUs**	**95,936 pounds**	**525 pounds**

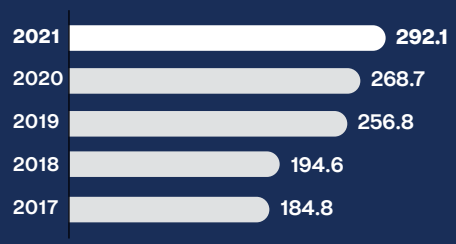
CVSHealth®

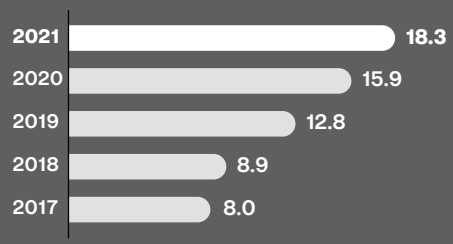
CVS Health
One CVS Drive, Woonsocket, RI 02895
401.765.1500
cvshealth.com

Healthier happens together™

CVS Health®

2021 Annual Report





Karen S. Lynch
President and Chief Executive Officer

Dear Fellow Stockholders:

At CVS Health, we are working to deliver a superior health care experience for consumers to improve health outcomes and lower costs, supporting individuals for every meaningful moment of health throughout their lives.

2021 was an important year for CVS Health
We advanced our strategy to deliver health care solutions that are personalized, connected, and increasingly digital in a dynamic market driven by evolving consumer needs. We enhanced our broad array of offerings, including essential mental and virtual health care services. We continued to help lead our nation's response to COVID-19 by administering tests and vaccinations to millions of Americans. When faced with the most significant public health challenge in our lifetime, people all across America trusted CVS Health.

Our 2021 performance highlighted our ability to anticipate, deliver, and exceed consumers' expectations for health care. This translated into strong results. We exceeded adjusted earnings per share expectations every quarter and surpassed our financial goals for the year.

Strength across our foundational businesses
Our results demonstrate the value of our integrated health solutions that leverage our deep health care expertise, portfolio of assets, and vast consumer touchpoints.

Strong execution led to success in our foundational businesses. The Health Care Benefits segment increased membership and revenue, delivering nearly 9 percent total revenue growth. This was driven by notable strength in Government Services and particularly Medicare growth, which experienced increases across all our product lines. Total Medicare Advantage membership grew 9.8 percent, with more than 265,000 new members added in the year, exceeding our initial growth expectations.

The Pharmacy Services segment also surpassed expectations, with full-year adjusted operating income growing more than 20 percent.* Our industry-leading management of drug cost trends, along with premier service and scale, helped fuel our record selling season of nearly $9 billion in net new business wins for 2022. Specialty Pharmacy continued to be a key growth driver, delivering revenue growth of 9.3 percent.

Our Retail/Long-Term Care (LTC) segment became the leading resource for testing and vaccinations throughout the pandemic, serving as a community health destination for millions of Americans. Last year, we administered more than 32 million COVID-19 tests and more than 59 million COVID-19 vaccines. Revenue grew 9.8 percent to just over $100 billion, marking an important milestone. Pharmacy sales and prescriptions filled both increased by nearly 9 percent, and front store sales outperformed as we successfully managed supply chain and labor challenges. We evaluated consumer health and buying needs, as well as shifts in the U.S. population, to create a plan that reduces the density of stores in some markets while maintaining our national presence.

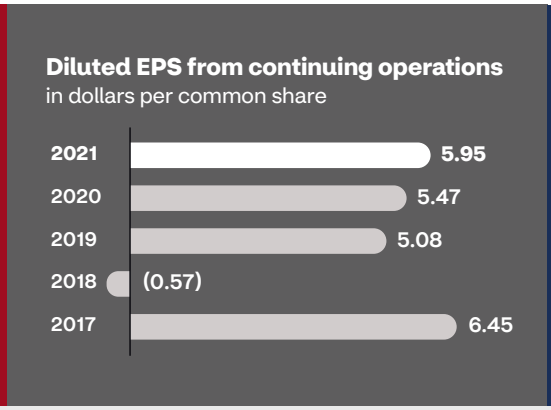
We have a strong foundation and are well positioned to realize the many opportunities to meet consumers' health needs.

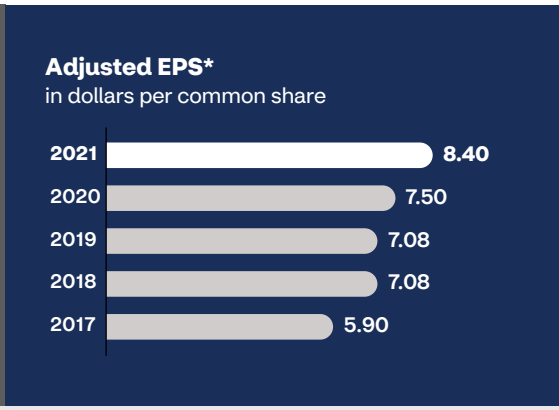
Delivering a superior health care experience and sustainable growth
In December, we shared our strategy to unify our foundational businesses and the bold moves we are making to bring greater value to the people we serve. Key to this strategy is advancing our care delivery and health services capabilities.

CVS Health has been involved in delivering health care services for years in communities, virtually and in peoples' homes. We offer acute, episodic care through our CVS Health retail clinic locations, as well as condition-specific care support through our clinical programs designed to address health issues such as diabetes, kidney disease, and obesity. We also provide health services in the home with personalized care for some of the most complex medical needs.

We are continuously innovating and evolving community-based care delivery, with our CVS HealthHUB® locations offering urgent care, mental health services, and more comprehensive primary care. Our HealthHUB locations exemplify our integrated omnichannel approach, combining face-to-face and digital points of care to meet consumers how and where they want.

We are advancing our care delivery and health services capabilities by shifting the model to be even more centered on the consumer, including multidisciplinary





care teams that work together to focus collectively on an individual's health and long-term goals. Deeper levels of engagement enable us to better manage the health outcomes and cost of care for the populations we serve.

Our community health locations play a powerful role in closing the gaps in care for all Americans, offering a convenient destination for the 85 percent of Americans who live within 10 miles of a CVS location. For the highest risk patients, with complex medical and social needs, we can provide care where they best need it: in the home. For almost everyone, our virtual care offerings offer speed, simplicity, and access, and in 2021, we supported 19 million virtual care visits across CVS Health.

We are simultaneously setting a new standard for digital health care for consumers. We forged new relationships with digital health innovators and have invested significantly in seamlessly connecting patients, their records, their doctors, hospitals, and other medical support.

CVS Health is uniquely positioned to play an integral role in offering affordable and convenient health solutions. We are connecting these channels, experiences, and care teams across the health care system to deliver better health outcomes.

Our commitment to performance with sustainable business practices

Importantly, we consistently achieve our goals with a commitment to sustainable business practices. It's our responsibility to ensure a healthier planet and healthier people for generations to come. We believe that our success depends on our diverse and inclusive workforce. In 2021, 58 percent of new colleagues and 51 percent of our overall workforce self-identified as racially or ethnically diverse, more than twice the average of the U.S. population.

We advanced health equity within each of our businesses and hired our first Chief Health Equity Officer. Our efforts were clear through our COVID-19 response, where more than one-third of vaccines administered in our CVS pharmacies were to members of underrepresented communities.

Our leadership in setting aggressive sustainable business targets is being recognized. We are proud to have been among the first seven companies globally to have net-zero greenhouse gas emissions targets validated by Science Based Targets initiative and to have been named to the Dow Jones Sustainability North America Index for the ninth year in a row.

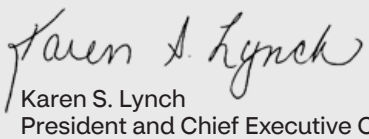
Defining the future of health care delivery

We have been thoughtful and deliberate in setting our vision and strategy for the future, creating a pathway to achieve low double-digit adjusted EPS growth over time. You can expect CVS Health to deliver strong sustainable growth in our foundational businesses and additional growth from our new initiatives. We will also drive meaningful cost improvements, generate powerful cash flow, and deploy that capital strategically. We recently increased our yearly dividend by 10 percent, from $2.00 to $2.20, and for the first time since 2017, our Board has authorized the company to begin repurchasing up to $10 billion in CVS Health stock. Our financial profile is strong: we generated nearly $18.3 billion in cash flow from operations in 2021, representing approximately 15 percent growth, and ended the year with $9.4 billion of cash and cash equivalents on hand.

We are a consumer-focused, purpose-driven company. I believe that our purpose and our people are our competitive edge. They are a key reason CVS Health so successfully navigated through such a challenging year. We have strong momentum into 2022. With our unique portfolio of assets, financial strength, consumer focus, and deep health care expertise, I am confident we will deliver for our members, clients, patients, customers, and stockholders.

In closing, let me thank our approximately 300,000 colleagues for their dedication, hard work, initiative, and innovation. And let me thank you, our stockholders, for investing in us. I look forward to another successful year.

Sincerely,



Karen S. Lynch
President and Chief Executive Officer

April 1, 2022

* Adjusted operating income and Adjusted EPS are non-GAAP financial measures. A reconciliation of operating income to adjusted operating income is provided on page 171 of the Form 10-K included in this Annual Report, and a reconciliation of GAAP diluted EPS from continuing operations to Adjusted EPS is provided under the heading "Reconciliation" in the back pages of this Annual Report.

Continued success in our foundational businesses

Delivering best-in-class service across all key capabilities

CVS Health is an established leader in critical segments of the health care industry, with a strong foundation that fuels our vision for the future. Our foundational businesses have generated strong results and significant operating cash flows. That success continued in 2021 with results that outpaced our expectations as we continue to prioritize high-growth areas going forward.

Health Care Benefits – We are focused on growing our Government Services businesses, including Medicare, Medicaid, and the dual eligible population. We also re-entered the ACA individual exchanges with our CVS-Aetna co-branded products in several states.

Pharmacy Services – We continue to lead with our capabilities and services to provide customers with industry-leading drug trend and customer care as a differentiator. We are also focused on capturing Specialty Pharmacy growth, including growing specialty generics and biosimilars.

Retail – The access CVS Health has to communities on a national scale is unmatched. Our capabilities during the pandemic have demonstrated the power of health care delivered locally and we continue to evolve our store models and omnichannel offerings. To accelerate our strategy, we are sharpening our focus in omnichannel pharmacy, deploying digital-first solutions and self-service tools, expanding into health services, and becoming the leader in health and wellness products. In 2021, we also announced our first Chief Pharmacy Officer to further our efforts in delivering an integrated health care experience.

As one of the most trusted brands in the nation, our deep relationships with more than 100 million members give us a distinct advantage. Centering our work around consumers at an unequaled scale enables us to drive deeper penetration of our health products and services and meet their everyday health needs. We are dramatically reshaping how they experience care, with a unique blend of consumer, health care, and risk management expertise all within one company.

Accelerating foundational growth

Better health outcomes and lower costs

Improved growth and adjusted operating margin

Greater customer lifetime value

Health Care Benefits

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
- Prescription Drug Plans (PDP)
- Medicaid health care management services
- health information technology products and services

Pharmacy Services

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
- medical spend management

Retail/Long-Term Care

The Retail/LTC segment sells prescription drugs and a wide assortment of health and wellness products and general merchandise, and:

- provides health care services through its walk-in medical clinics
- provides medical diagnostic testing, administers vaccinations for illnesses such as influenza, COVID-19, and shingles
- conducts LTC operations, which distribute prescription drugs and provide other ancillary services to chronic care facilities and other care settings

Unparalleled consumer reach

59+ million
COVID-19 vaccines and 32+ million COVID-19 tests administered

100+ million
members with Aetna and Caremark

9,000+
retail locations with ~1,200 walk-in clinics

~4.5 million
consumers visit CVS Health locations daily

2.4%
overall drug trend and 5.8% specialty trend through the first three quarters of 2021

In-person care

Hands-on care is vital to successful health outcomes, including its seamless integration with virtual care. Our physical presence, collection of assets, digital tools, and strong consumer trust in our brand uniquely position us closest to the consumer to address their health needs holistically.

In-home care

Home care represents a significant opportunity. We are uniquely positioned to integrate our existing capabilities – along with new products and services – to create a new ecosystem: enabling the home as a new, technology-enabled site of care.

Virtual care

The future of health will be digitally led. Digital engagement drives better outcomes for the consumer and our business. In 2021, we extended our virtual care capabilities with the launch of our nationwide Virtual First Primary Care product. We also completed 19 million virtual visits across CVS and Aetna, including 10 million virtual behavioral health sessions, during the year.

Designing with a consumer focus to remove physical barriers to care

- Deeper engagement
- Greater satisfaction
- Better health outcomes
- Lower cost to serve

4,000+
nurse practitioners and physician assistants currently employed

40 million
unique digital customers

19 million
virtual visits across CVS and Aetna in 2021, including 10 million behavioral health visits

Creating a truly consumer-centric care delivery model

New services focused on the needs of our consumers

Comprehensive primary care services
We are expanding on our primary care services to fill gaps in a health system that is expensive, inconvenient, and fragmented. Primary care is the first point of entry into the health system and significantly influences health care utilization.

Our holistic, next-generation primary care model will employ a multidisciplinary team approach to support patients across clinic, home, and virtual access points. A comprehensive, relationship-based, omnichannel model will allow us to better meet the needs of patients and providers, while our community locations – both HealthHUBs and convenient pharmacies – will play a key role in supporting this care. HealthHUBs will extend primary care for specific lower risk use cases, allowing us to significantly expand our patient panel size and lower costs. Our pharmacies will leverage existing touchpoints to provide ancillary and complementary services like Next Best Actions (NBAs) and medication adherence programs.

Treating the whole person – the physical, emotional, social, and economic – leads to better outcomes and maximizes our relationship with the consumer for lifetime value.

Removing barriers to care with a digital-first consumer experience
Our vision for a seamless connected experience across all our assets comes together at CVS.com, where consumers can find one-stop solutions for their health care journey. CVS.com is one of the top health sites in the U.S. with more than 2 billion visits in 2021, up nearly 55 percent over the prior year. We now serve 40 million unique digital consumers, up approximately 10 percent in the last six months of 2021 alone.

We continue to add new digital capabilities at an aggressive pace and invest in emerging technologies to power differentiated consumer experiences and optimize our cost structure.

Comprehensive primary care services focused on the needs of seniors and caregivers

- Team-based, doctor-led primary care
- Integrated behavioral health
- Social services support
- Provider-led care coordination

Making health more seamless, convenient, and personalized

Enhancing omnichannel health delivery

The premier community health and wellness destination
Our community presence is a key enabler for our strategy. The path to improving health outcomes is through engagement. Each week, we see more than 21 million trips to our CVS Health stores and nearly 11 million interactions with our pharmacists. This reach allows us to engage with consumers about their health in unique ways.

As we deepen our commitment to the consumer health experience, we are reconfiguring our CVS stores into three formats: primary care centers that provide the highest level of clinical service, an enhanced version of our CVS HealthHUB with products and services to support everyday health and wellness needs, and our traditional CVS Pharmacy locations. Both HealthHUB and CVS Pharmacy locations serve as care extenders.

The engine for everyday health engagement
At the heart of our everyday engagements are our new digital services and leading platforms.

For example, CarePass®, our health and wellness subscription, grew membership more than 40 percent in 2021. We made it easier to enroll, integrated millions of Aetna members, and offered popular services like self-service digital check-in for non-test appointments. This drives extensive digital engagement, along with more frequent trips and bigger "baskets."

To accelerate our omnichannel health strategy, we are sharpening our focus where it matters most: leading in omnichannel pharmacy, deploying digital-first solutions and self-service tools, expanding into health services, and becoming the leader in health and wellness products.

This mix of digital and in-person capabilities sets us apart and presents a tremendous opportunity to offer Aetna and Caremark members digital self-service tools with increased convenience, improved health, and lower costs.

Optimizing CVS stores into three formats

Primary care centers
Providing the highest level of clinical service

HealthHUB
Products and services to support everyday health and wellness needs

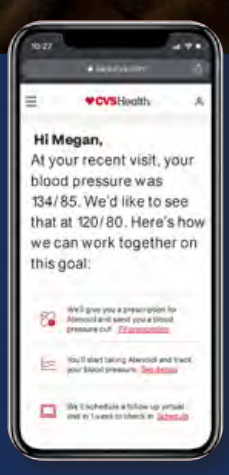
CVS Pharmacy
85% of Americans live within 10 miles of a CVS Pharmacy

Driving engagement across platforms

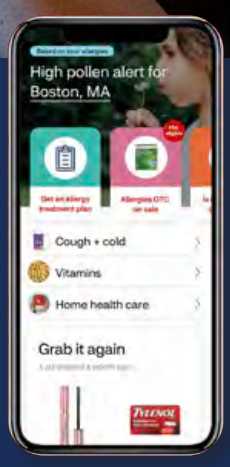
~92%
of CVS Specialty members have opted into our digital programs

>40% growth
to ~5.6 million members in CarePass, our paid health and wellness subscription platform

Personalized health care solutions at your fingertips



New features, such as after-visit summaries, medications, and third-party lab results



Deep personalization and expanded health and wellness eCommerce

Easy self-service tools to start, refill, and check status of prescriptions

Investing in the health of our communities and the planet

At CVS Health, we are advancing the health care experience with a clear understanding of our environmental, social, and governance (ESG) impacts on our business, communities, and the planet. ESG is embedded in our culture and is reflected in our everyday actions to increase access to health care, support diversity and inclusion, give back to local communities, or reduce our environmental impact.

We continued to invest in health equity throughout 2021 and are proud of our work detailed in our ESG report. Our diversity management strategy is focused on increasing workforce representation, promoting inclusion and belonging, ensuring equitable access to growth and development, and being consumer-obsessed in serving an ever-changing and diverse base of customers, patients, and members.

Our ESG strategy leverages a scientific approach to stakeholder engagement. We conduct materiality assessments with key constituencies to inform performance goals and our ability to lead, follow, and monitor trends.

As part of our ten-year Sustainability roadmap, Healthy 2030, we have set long-term goals to guide our focus on key topics and have aligned to eight of the U.N. Sustainable Development Goals. Our goals for this decade include a commitment to invest in wellness and economic development and advancement opportunities, as well as initiatives to address racial inequity. We also continue to execute our commitment to reduce our environmental impact by at least 50 percent by 2030, anchored by our science-based, net zero 2050 target to reduce emissions in the near and long term. Learn more at CVSHealth.com/reporting and our upcoming 2021 Environmental, Social, and Governance Report.

Committed to diversity and health equity

45%
of CVS Pharmacists self-identify as racially or ethnically diverse compared to 34% national average

8,100
registered apprentices, 80% of whom are women

159 million
meals for people who are food insecure, with ~40% of meals for people of color suffering from food insecurity

Healthy People
We are committed to delivering health care products and services that create a more affordable, accessible, and convenient health care experience for all.

Healthy Business
We are a business that is inclusive and committed to creating value for our colleagues, shareholders, business partners, and supply chain.

Healthy Community
We are committed to improving the health and wellbeing of our communities and advancing health equity to ensure everyone has a fair and just opportunity to be as healthy as possible.

Healthy Planet
We are committed to achieving net zero emissions, reducing waste, providing customers with sustainable product offerings, and embedding sustainable practices across our supply chain.

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

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	☐
Non-accelerated filer	☐	Smaller reporting company	☐
		Emerging growth company	☐

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

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

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 $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.

TABLE OF CONTENTS

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.

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.

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.

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	—

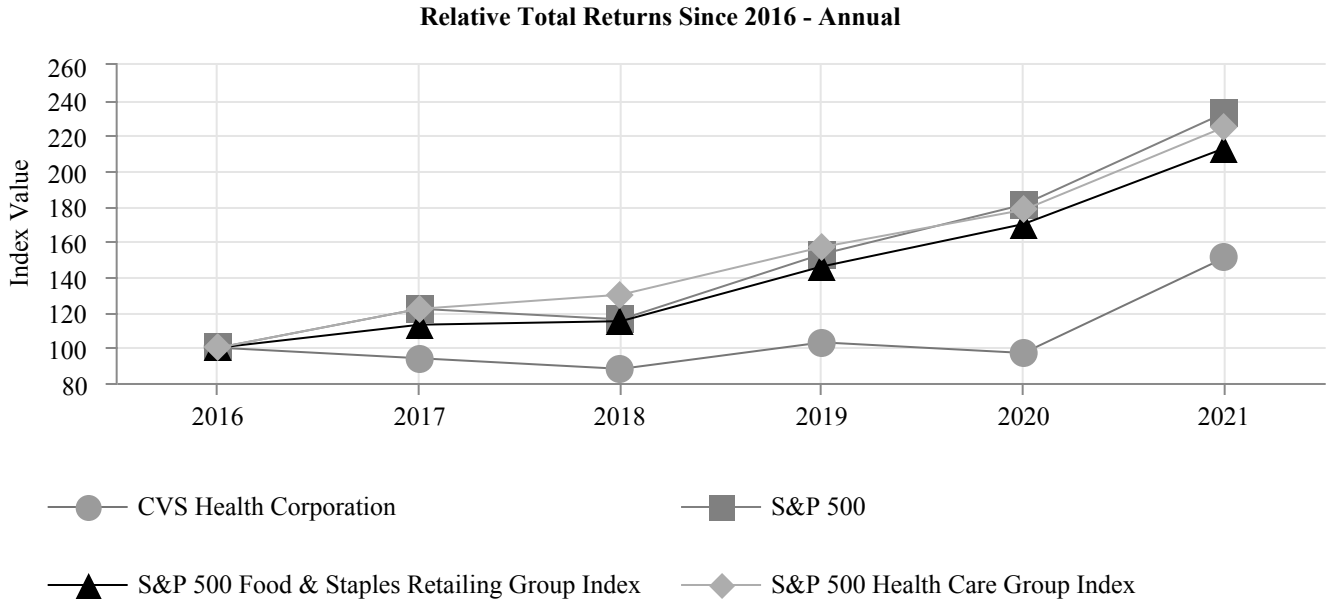
Each of the share Repurchase Programs was effective immediately. The 2016 Repurchase program was terminated effective December 9, 2021. The 2021 Repurchase Program permits the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, 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.

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:

	Year Ended December 31,			Change 2021 vs. 2020		Change 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.

Index to Consolidated Financial Statements

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.

Consolidated Balance Sheets

In millions, except per share amounts	At December 31, 2021	At December 31, 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

In millions	For the Years Ended December 31, 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:

	Carrying	Estimated Fair Value			
In millions	**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)
Long-term debt	$ 51,971	$ 59,207

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.

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.

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.

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 **Fernando Aguirre**	Director	February 9, 2022
/s/ C. DAVID BROWN II **C. David Brown II**	Director	February 9, 2022
/s/ JAMES D. CLARK **James D. Clark**	Senior Vice President - Controller and Chief Accounting Officer (Principal Accounting Officer)	February 9, 2022
/s/ ALECIA A. DECOUDREAUX **Alecia A. DeCoudreaux**	Director	February 9, 2022
/s/ NANCY-ANN M. DEPARLE **Nancy-Ann M. DeParle**	Director	February 9, 2022
/s/ DAVID W. DORMAN **David W. Dorman**	Chair of the Board and Director	February 9, 2022
/s/ ROGER N. FARAH **Roger N. Farah**	Director	February 9, 2022
/s/ ANNE M. FINUCANE **Anne M. Finucane**	Director	February 9, 2022
/s/ SHAWN M. GUERTIN **Shawn M. Guertin**	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 9, 2022
/s/ EDWARD J. LUDWIG **Edward J. Ludwig**	Director	February 9, 2022
/s/ KAREN S. LYNCH **Karen S. Lynch**	President and Chief Executive Officer (Principal Executive Officer) and Director	February 9, 2022
/s/ JEAN-PIERRE MILLON **Jean-Pierre Millon**	Director	February 9, 2022
/s/ MARY L. SCHAPIRO **Mary L. Schapiro**	Director	February 9, 2022
/s/ WILLIAM C. WELDON **William C. Weldon**	Director	February 9, 2022
/s/ TONY L. WHITE **Tony L. White**	Director	February 9, 2022

Reconciliation

Adjusted Earnings Per Share (Unaudited)

CVS Health Corporation together with its subsidiaries (collectively, "CVS Health" or the "Company") uses non-GAAP financial measures to analyze underlying business performance and trends. The Company believes that providing these non-GAAP financial measures enhances the Company's and investors' ability to compare the Company's past financial performance with its current performance. These non-GAAP financial measures are provided as supplemental information to the financial measures the Company discloses that are calculated and presented in accordance with GAAP. Non-GAAP financial measures should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP. The Company's definitions of its non-GAAP financial measures may not be comparable to similarly titled measurements reported by other companies.

GAAP diluted EPS from continuing operations and Adjusted EPS, respectively, are calculated by dividing income (loss) from continuing operations attributable to CVS Health and adjusted income from continuing operations attributable to CVS Health by the Company's weighted average diluted shares outstanding. The Company defines adjusted income from continuing operations attributable to CVS Health as income (loss) from continuing operations attributable to CVS Health (GAAP measure) excluding the impact of amortization of intangible assets and other items, if any, that neither relate to the ordinary course the Company's business nor reflect the Company's underlying business performance, such as acquisition-related transaction and integration costs, store impairments, goodwill impairments, acquisition purchase price adjustments outside of the acquisition accounting measurement period, gains/losses on divestitures, income associated with the receipt of fully reserved amounts owed to the Company under the ACA risk corridor program, impairments of long-lived assets, losses on settlements of defined benefit pension plans, losses on early extinguishment of debt, net interest expense on financings associated with proposed acquisitions (for periods prior to the acquisition), the corresponding tax benefit or expense related to the items excluded from adjusted income from continuing operations attributable to CVS Health and the corresponding impact to income allocable to participating securities, net of tax, related to the items excluded from income from continuing operations attributable to CVS Health in determining adjusted income from continuing operations attributable to CVS Health.

The following are reconciliations of income (loss) from continuing operations attributable to CVS Health to adjusted income from continuing operations attributable to CVS Health and calculations of GAAP diluted EPS from continuing operations and Adjusted EPS:

	Year Ended December 31,				
In millions, except per share data	**2021**	**2020**	**2019**	**2018**	**2017**
Income (loss) from continuing operations (GAAP measure)	$ 7,898	$ 7,201	$ 6,631	$ (596)	$ 6,631
Net (income) loss attributable to noncontrolling interests (GAAP measure)	12	(13)	3	2	(1)
Income allocable to participating securities (GAAP measure)	—	—	(5)	(3)	(24)
Income (loss) from continuing operations attributable to CVS Health (GAAP measure)	7,910	7,188	6,629	(597)	6,606
Non-GAAP adjustments:					
Amortization of intangible assets [1]	2,259	2,341	2,436	1,006	817
Acquisition-related transaction and integration costs [2]	132	332	480	492	65
Store impairments [3]	1,358	—	231	—	215
Goodwill impairments [4]	431	—	—	6,149	181
Acquisition purchase price adjustment outside of measurement period [5]	(61)	—	—	—	—
(Gain) loss on divestiture of subsidiary [6]	—	(269)	205	86	9
Receipt of fully reserved ACA risk corridor receivable [7]	—	(307)	—	—	—
Impairment of long-lived assets [8]	—	—	—	43	—
Losses on settlements of defined benefit pension plans [9]	—	—	—	—	187
Loss on early extinguishment of debt [10]	452	1,440	79	—	—
Net interest expense on financing activities [11]	—	—	—	894	56
Tax impact of non-GAAP adjustments [12]	(1,316)	(877)	(815)	(658)	(2,096)
Receipt of fully reserved ACA risk corridor receivable attributable to noncontrolling interest, net of tax [7]	—	12	—	—	—
Income allocable to participating securities, net of tax [13]	—	—	(1)	(9)	2
Adjusted income from continuing operations attributable to CVS Health	$ 11,165	$ 9,860	$ 9,244	$ 7,406	$ 6,042
Weighted average diluted shares outstanding (GAAP)	1,329	1,314	1,305	1,044	1,024
Adjusted weighted average diluted shares outstanding (non-GAAP) [14]	1,329	1,314	1,305	1,047	1,024
GAAP diluted earnings per share from continuing operations	$ 5.95	$ 5.47	$ 5.08	$ (0.57)	$ 6.45
Adjusted EPS	$ 8.40	$ 7.50	$ 7.08	$ 7.08	$ 5.90

Footnotes

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 condensed 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 acquisition of Aetna Inc. (the "Aetna Acquisition"). In 2018 and 2017, acquisition-related transaction and integration costs relate to the Aetna Acquisition and the acquisition of Omnicare, Inc.
3) In 2021, the store impairment charge relates to 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. In 2019, the store impairment charges relate to the to write down of operating lease right-of-use assets and property and equipment in connection with the planned closure of 68 underperforming retail pharmacy stores in 2019 and 2020. In 2017, the store impairment charges primarily represent charges for noncancelable lease obligations associated with stores closed in connection with the Company's enterprise streamlining initiative.
4) In 2021 and 2018, the goodwill impairment charges relate to the LTC reporting unit within the Retail/LTC segment. In 2017, the goodwill impairment charges relate to the RxCrossroads 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.
6) In 2020, the gain on divestiture of subsidiary represents the pre-tax gain on the sale of the Workers' Compensation business, which was sold on July 31, 2020 for approximately $850 million. In 2019, the loss on divestiture of subsidiary represents the pre-tax loss on the sale of the Company's Brazilian subsidiary, Drogaria Onofre Ltda., which occurred on July 1, 2019, and 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 ("RxCrossroads") for $725 million on January 2, 2018. In 2017, the loss on divestiture of subsidiary represents transaction costs associated with the sale of RxCrossroads.
7) In 2020, the Company received $313 million owed to it under the Patient Protection and Affordable Care Act and the Health Care Education Reconciliation Act of 2010 (collectively, the "ACA") 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 rebate requirements and premium taxes, the Company recognized pre-tax income of $307 million. The portion of the ACA risk corridor payment attributable to noncontrolling interest was $12 million related to third party ownership interests in the Company's consolidated operating entities.

8) In 2018, impairment of long-lived assets primarily relates to the impairment of property and equipment within the Retail/LTC segment.
9) In 2017, the Company settled the pension obligations of its two tax-qualified 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 the pension plan assets, resulted in pre-tax settlement losses related to the recognition of accumulated deferred actuarial losses.
10) In 2021, the loss on early extinguishment of debt related 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 and the Company's repayment of approximately $2.0 billion of its outstanding senior notes in August 2021 pursuant to its tender offer for such senior notes. In 2020, the loss on early extinguishment of debt related to the Company's repayment of $4.5 billion of its outstanding senior notes in December 2020 pursuant to its tender offers for such senior notes and the Company's repayment of $6.0 billion of its outstanding senior notes in August 2020 pursuant to its tender offers for such senior notes. In 2019, the loss on early extinguishment of debt related to the Company's repayment of $4.0 billion of its outstanding senior notes in August 2019 pursuant to its tender offers for such senior notes.
11) In 2018, net interest expense on financing activities includes interest expense related to (i) bridge financing costs, (ii) interest expense on $40 billion of unsecured senior notes issued on March 9, 2018 (the "2018 Notes") and (iii) interest expense on the Company's $5 billion term loan facility relating to the Aetna Acquisition. The interest expense was reduced by related interest income earned on the proceeds of the 2018 Notes. All amounts are for the periods prior to the close of the Aetna Acquisition, which occurred on November 28, 2018. In 2017, net interest expense on financing activities includes bridge financing costs related to the Aetna Acquisition.
12) Represents the corresponding tax benefit or expense related to the items excluded from adjusted income from continuing operations attributable to CVS Health and Adjusted EPS above. The nature of each non-GAAP adjustment is evaluated to determine whether a discrete adjustment should be made to the adjusted income tax provision. In 2021, the Company's non-GAAP tax provision also excludes certain tax benefits primarily related to IRS approval of a prior year tax refund claim. In 2020, the Company realized certain tax losses that were able to be used to offset a portion of the taxable gain related to the July 2020 sale of the Workers' Compensation business, which reduced total tax expense in 2020.
13) Represents the corresponding impact to income allocable to participating securities, net of tax, related to the items above excluded from income (loss) from continuing operations attributable to CVS Health in determining adjusted income from continuing operations attributable to CVS Health and calculating Adjusted EPS above.
14) Adjusted EPS for the year ended December 31, 2018 is calculated utilizing adjusted weighted average diluted shares outstanding, which includes 3 million potential common equivalent shares, as the impact of these shares was dilutive. The potential common equivalent shares were excluded from the calculation of GAAP loss per share from continuing operations for the year ended December 31, 2018, as the shares would have had an anti-dilutive effect as a result of the GAAP net loss incurred.

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Officer, Director, and Stockholder Information

Officers

Karen S. Lynch
President and Chief Executive Officer

Shawn M. Guertin
Executive Vice President and Chief Financial Officer

Jonathan C. Roberts
Executive Vice President and Chief Operating Officer

Troyen A. Brennan, M.D.
Executive Vice President and Chief Medical Officer

David A. Falkowski
Executive Vice President and Chief Compliance Officer

Daniel P. Finke
Executive Vice President and President – Health Care Benefits

Joshua M. Flum
Executive Vice President – Enterprise Strategy

Laurie P. Havanec
Executive Vice President and Chief People Officer

Alan M. Lotvin, M.D.
Executive Vice President and President – Pharmacy Services

Thomas M. Moriarty
Executive Vice President, Chief Policy and External Affairs Officer, and General Counsel

Michelle A. Peluso
Executive Vice President, Chief Customer Officer and Co-President – Retail

Prem S. Shah
Executive Vice President, Chief Pharmacy Officer and Co-President – Retail

David L. Casey
Senior Vice President and Chief Diversity Officer

James D. Clark
Senior Vice President – Controller and Chief Accounting Officer

Tom F. Cowhey
Senior Vice President – Capital Markets

Carol A. DeNale
Senior Vice President and Treasurer

Colleen M. McIntosh
Senior Vice President, Secretary, Chief Governance Officer and Assistant General Counsel

Thomas S. Moffatt
Vice President, Asst. Secretary and Sr. Legal Counsel – Corporate Services

OFFICERS' CERTIFICATIONS
The Company has filed the required certifications under Section 302 of the Sarbanes-Oxley Act of 2002 regarding the quality of our public disclosures as Exhibits 31.1 and 31.2 to our Annual Report on Form 10-K for the fiscal year ended December 31, 2021. After our 2021 annual meeting of stockholders, the Company filed with the New York Stock Exchange the CEO certification regarding its compliance with the NYSE corporate governance listing standards as required by NYSE Rule 303A.12(a).

Directors

Fernando Aguirre (1) (5)
Former Chairman and Chief Executive Officer, Chiquita Brands International, Inc.

C. David Brown II (3) (5) (6)
Partner and Former Member of the Executive Committee, Nelson Mullins Riley & Scarborough LLP

Alecia A. DeCoudreaux (1) (4)
President Emerita, Mills College and Former Executive, Eli Lilly and Company

Nancy-Ann M. DeParle (4) (5) (6)
Managing Partner and Co-Founder, Consonance Capital Partners, LLC and Former Deputy Chief of Staff and Director of the White House Office of Health Reform

David W. Dorman (3) (5) (6)
Chair of the Board, CVS Health Corporation and Former Chairman and CEO, AT&T Corporation

Roger N. Farah (3) (4)
Former Chairman of the Board, Tiffany & Co. and Former Executive, Tory Burch and Ralph Lauren

Anne M. Finucane (2) (3) (6)
Chairman of the Board, Bank of America Europe DAC and Former Vice Chairman, Bank of America Corporation

Edward J. Ludwig (1) (2) (6)
Former Chairman and Chief Executive Officer, Becton, Dickinson and Company

Karen S. Lynch (6)
President and Chief Executive Officer, CVS Health Corporation

Jean-Pierre Millon (1) (4)
Former President and Chief Executive Officer, PCS Health Systems, Inc.

Mary L. Schapiro (1) (2)
Vice Chair for Public Policy and Special Advisor to the Founder and Chairman, Bloomberg L.P., and Former Chairman of the U.S. Securities and Exchange Commission

William C. Weldon (3) (5)
Former Chairman and Chief Executive Officer, Johnson & Johnson

Tony L. White (3) (4) (6)
Former Chairman, President and Chief Executive Officer, Applied Biosystems, Inc.

(1) Audit Committee
(2) Investment and Finance Committee
(3) Management Planning and Development Committee
(4) Medical Affairs Committee
(5) Nominating and Corporate Governance Committee
(6) Executive Committee

Stockholder Information

Corporate Headquarters
CVS Health Corporation
One CVS Drive
Woonsocket, RI 02895
(401) 765-1500

Annual Stockholders' Meeting
May 11, 2022
www.virtualshareholdermeeting.com/CVS2022

Stock Market Listing
The New York Stock Exchange
Symbol: CVS

Transfer Agent and Registrar
Questions regarding stock holdings, certificate replacement/transfer, dividends and address changes should be directed to:

EQ Shareowner Services
P.O. Box 64874
St. Paul, MN 55164-0874
Toll-free: (877) CVS-PLAN (287-7526)
International: +1 (651) 450-4064
Email: stocktransfer@eq-us.com
Website: www.shareowneronline.com

Direct Stock Purchase/Dividend Reinvestment Program
Shareowner Services Plus Plan℠ provides a convenient and economical way for you to purchase your first shares or additional shares of CVS Health common stock. The program is sponsored and administered by EQ Shareowner Services. For more information, including an enrollment form, please contact EQ Shareowner Services at (877) 287-7526.

Annual Report on Form 10-K and Other Company Information
The Company's Annual Report on Form 10-K will be sent without charge to any stockholder upon request by contacting:

CVS Health Corporation
Investor Relations Office
One CVS Drive, MC 1008
Woonsocket, RI 02895
(800) 201-0938

In addition, financial reports and recent filings with the Securities and Exchange Commission, including our Form 10-K, as well as other Company information, are available via the Internet at investors.cvshealth.com.

designed and produced by **see see eye**

CVS Health

CVS Health
One CVS Drive, Woonsocket, RI 02895
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