

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

**Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934  
For the fiscal year ended December 31, 2018**

OR

**Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934  
For the transition period from \_\_\_\_\_ to \_\_\_\_\_  
Commission file number 001-01011**



**CVS HEALTH CORPORATION**  
(Exact name of registrant as specified in its charter)

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

**05-0494040**  
(I.R.S. Employer Identification No.)  
**02895**  
(Zip Code)

**(401) 765-1500**

(Registrant's telephone number, including area code)

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

**Common Stock, par value \$0.01 per share**  
Title of each class

**New York Stock Exchange**  
Name of each exchange on which registered

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

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.  Yes  No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.  Yes  No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.  Yes  No

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files).  Yes  No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer  Accelerated filer

Non-accelerated filer  Smaller reporting company

Emerging growth company

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

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act).  Yes  No

The aggregate market value of the registrant's common stock held by non-affiliates was approximately \$65,262,991,789 as of June 30, 2018, based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be the affiliates of the registrant.

As of February 19, 2019, the registrant had 1,297,082,165 shares of common stock issued and outstanding.

**DOCUMENTS INCORPORATED BY REFERENCE**

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

Portions of the Annual Report to Stockholders for the fiscal year ended December 31, 2018 (the "Annual Report") are incorporated by reference in response to Items 1, 1A, 2 and 3 of Part I and Items 5, 6, 7, 7A, 8 and 9A of Part II, in each case to the extent described therein.

Information contained in the definitive proxy statement for CVS Health Corporation's 2019 Annual Meeting of Stockholders, to be filed on or about April 5, 2019 (the "Proxy Statement"), is incorporated by reference in response to Items 10 through 14 of Part III to the extent described therein.

## TABLE OF CONTENTS

	<u>Page</u>
<b>Part I</b>	
Item 1: <a href="#">Business</a>	<a href="#">1</a>
Item 1A: <a href="#">Risk Factors</a>	<a href="#">28</a>
Item 1B: <a href="#">Unresolved Staff Comments</a>	<a href="#">59</a>
Item 2: <a href="#">Properties</a>	<a href="#">59</a>
Item 3: <a href="#">Legal Proceedings</a>	<a href="#">60</a>
Item 4: <a href="#">Mine Safety Disclosures</a>	<a href="#">60</a>
<b>Part II</b>	
Item 5: <a href="#">Market for Registrant’s Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities</a>	<a href="#">61</a>
Item 6: <a href="#">Selected Financial Data</a>	<a href="#">62</a>
Item 7: <a href="#">Management’s Discussion and Analysis of Financial Condition and Results of Operations</a>	<a href="#">62</a>
Item 7A: <a href="#">Quantitative and Qualitative Disclosures About Market Risk</a>	<a href="#">62</a>
Item 8: <a href="#">Financial Statements and Supplementary Data</a>	<a href="#">62</a>
Item 9: <a href="#">Changes in and Disagreements with Accountants on Accounting and Financial Disclosure</a>	<a href="#">62</a>
Item 9A: <a href="#">Controls and Procedures</a>	<a href="#">62</a>
Item 9B: <a href="#">Other Information</a>	<a href="#">63</a>
<b>Part III</b>	
Item 10: <a href="#">Directors, Executive Officers and Corporate Governance</a>	<a href="#">63</a>
Item 11: <a href="#">Executive Compensation</a>	<a href="#">64</a>
Item 12: <a href="#">Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters</a>	<a href="#">64</a>
Item 13: <a href="#">Certain Relationships and Related Transactions and Director Independence</a>	<a href="#">65</a>
Item 14: <a href="#">Principal Accountant Fees and Services</a>	<a href="#">65</a>
<b>Part IV</b>	
Item 15: <a href="#">Exhibits and Financial Statement Schedules</a>	<a href="#">66</a>
Item 16: <a href="#">Form 10-K Summary</a>	<a href="#">70</a>
<a href="#">Signatures</a>	<a href="#">71</a>

## PART I

### Item 1. Business

#### Overview

CVS Health Corporation, together with its subsidiaries (collectively, “CVS Health,” the “Company,” “we,” “our” or “us”), is the nation’s premier health innovation company helping people on their path to better health. Whether in one of its pharmacies or through its health services and plans, CVS Health is pioneering a bold new approach to total health by making quality care more affordable, accessible, simple and seamless. CVS Health is community-based and locally focused, engaging consumers with the care they need when and where they need it. The Company has more than 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 92 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year, expanding specialty pharmacy services, and a leading stand-alone Medicare Part D prescription drug plan. CVS Health also serves an estimated 38 million people through traditional, voluntary and consumer-directed health insurance products and related services, including rapidly expanding Medicare Advantage offerings. The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

On November 28, 2018 (the “Aetna Acquisition Date”), the Company acquired Aetna Inc. (“Aetna”) for a combination of cash and CVS Health stock (the “Aetna Acquisition”). The Company acquired Aetna to help improve the consumer health care experience by combining Aetna’s health care benefits products and services with CVS Health’s more than 9,900 retail locations, approximately 1,100 walk-in medical clinics and integrated pharmacy capabilities with the goal of becoming the new, trusted front door to health care. Under the terms of the merger agreement, Aetna shareholders received \$145.00 in cash and 0.8378 CVS Health shares for each Aetna share. The transaction valued Aetna at approximately \$212 per share or approximately \$70 billion. Including the assumption of Aetna’s debt, the total value of the transaction was approximately \$78 billion. The Company financed the cash portion of the purchase price through a combination of cash on hand and by issuing approximately \$45.0 billion of new debt, including senior notes and term loans. For additional information, see Note 2 “Acquisition of Aetna” contained in the “Notes to Consolidated Financial Statements” in the Annual Report, which is incorporated by reference herein.

On October 10, 2018, the Company and Aetna entered into a consent decree with the United States Department of Justice (the “DOJ”) that allowed the Company’s proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone Medicare Part D prescription drug plans. As part of the agreement reached with the DOJ, Aetna entered into a purchase agreement with a subsidiary of WellCare Health Plans, Inc. (“WellCare”) for the divestiture of Aetna’s standalone Medicare Part D prescription drug plans effective December 31, 2018. On November 30, 2018, Aetna completed the sale of its standalone Medicare Part D prescription drug plans. Aetna’s standalone Medicare Part D prescription drug plans had an aggregate of approximately 2.3 million members as of December 31, 2018. Aetna will provide administrative services to, and will retain the financial results of, the divested plans through 2019.

As a result of the Aetna Acquisition, the Company added the Health Care Benefits segment, which is the equivalent of the former Aetna Health Care segment. Certain aspects of Aetna’s operations, including products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, are included in the Company’s Corporate/Other segment. The Company now has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other.

#### Business Strategy

The combined company expects to transform the consumer health care experience and build healthier communities through a new innovative health care model that is local, easier to use, less expensive and puts consumers at the center of their care. The Company believes that improving the consumer’s health care experience will improve consumer engagement with their health which will lead to improved health outcomes and lower total health care costs. The Company believes there are three imperatives to accomplishing this transformation: be local, make it simple and improve health. These imperatives also guide the Company’s five key strategies for delivering medical cost savings for its customers: improve common chronic disease management, reduce unnecessary hospital readmissions, improve the efficiency of the sites at which medical members receive care, optimize primary care delivery and improve the Company’s complex chronic disease management capabilities.

## **Pharmacy Services Segment**

The Pharmacy Services segment provides a full range of pharmacy benefit management (“PBM”) solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services, mail order pharmacy, specialty pharmacy and infusion services, Medicare Part D services, clinical services, disease management services and medical spend management. The Pharmacy Services segment’s clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D prescription drug plans (“PDPs”), Medicaid managed care (“Managed Medicaid”) plans, plans offered on public health insurance exchanges (“Public Exchanges”) and private health insurance exchanges (“Private Exchanges” and together with Public Exchanges, “Insurance Exchanges”), other sponsors of health benefit plans and individuals throughout the United States. In addition, the Company is a national provider of drug benefits to eligible beneficiaries under the Medicare Part D prescription drug program. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services. During the year ended December 31, 2018, the Company’s PBM filled or managed approximately 1.9 billion prescriptions on a 30-day equivalent basis.

### ***PBM Services***

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

#### ***Plan Design Offerings and Administration***

The Company administers pharmacy benefit plans for clients who contract with it to facilitate prescription drug coverage and claims processing for their eligible plan members. The Company assists its PBM clients in designing pharmacy benefit plans that help improve health outcomes while minimizing the costs to the client. The Company also assists PBM clients in monitoring the effectiveness of their plans through frequent, informal communications, the use of proprietary software, as well as through formal annual, quarterly and sometimes monthly performance reviews.

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

#### ***Formulary Management***

The Company utilizes an independent panel of doctors, pharmacists and other medical experts, referred to as the CVS Caremark National Pharmacy and Therapeutics Committee, to review and approve the selection of drugs that meet the Company’s standards of safety and efficacy for inclusion on one of the Company’s template formularies. The Company’s formularies provide recommended products in numerous drug classes to help ensure member access to clinically appropriate drugs with alternatives within a class under the client’s pharmacy benefit plan, while helping to drive the lowest net cost for clients that select one of the Company’s formularies. To help improve clinical outcomes for members and clients, the Company conducts ongoing, independent reviews of all drugs, including, but not limited to, those appearing on the formularies and generic equivalent products. Many of the Company’s clients choose to adopt a template formulary offering as part of their plan design. Beginning in 2018, clients had new capabilities to offer real time benefits information for a member’s specific plan design, provided digitally at the point of prescribing, at the pharmacy and directly to members.

#### ***Retail Pharmacy Network Management Services***

The Company maintains a national network of more than 68,000 retail pharmacies, consisting of approximately 41,000 chain pharmacies (which includes CVS Pharmacy locations) and 27,000 independent pharmacies, in the United States, including Puerto Rico, the District of Columbia, Guam and the United States Virgin Islands. When a customer fills a prescription in a retail pharmacy, the pharmacy sends prescription data electronically to the Company from the point-of-sale. This data interfaces with the Company’s proprietary prescription management systems, which verify relevant plan member data and eligibility, while also performing a drug utilization review to help evaluate clinical appropriateness and safety and confirming that the pharmacy will receive payment for the prescription. The Company is also able to build client-specific pharmacy networks and

managed pharmacy network solutions to further drive savings for clients. These include a performance-based pharmacy network with approximately 30,000 stores that is anchored by CVS Pharmacy and Walgreens, along with up to 10,000 independent pharmacies across the United States. The performance-based network is designed to deliver unit cost savings and to improve clinical outcomes in order to help to lower overall health care costs for participating payors and their members.

#### *Mail Order Pharmacy Services*

The Pharmacy Services segment operates mail order dispensing pharmacies in the United States. Plan members or their prescribers submit prescriptions or refill requests, primarily for maintenance medications, to these pharmacies via mail, telephone, fax, e-prescribing or the Internet, and staff pharmacists review these prescriptions and refill requests with the assistance of the Company's prescription management systems. This review may involve communications with the prescriber and, with the prescriber's approval when required, can result in generic substitution, therapeutic interchange or other actions designed to help reduce cost and/or improve quality of treatment. The Company's mail order dispensing pharmacies have been awarded Mail Order Pharmacy accreditation from Utilization Review Accreditation Commission ("URAC"), a health care accrediting organization that establishes quality standards for the health care industry.

#### *Specialty Pharmacy and Infusion Services*

The Pharmacy Services segment operates specialty mail order pharmacies, retail specialty pharmacy stores and branches for infusion and enteral nutrition services in the United States. These specialty mail order pharmacies are used for delivery of advanced medications to individuals with chronic or genetic diseases and disorders. The Company's specialty mail order pharmacies also have been awarded Specialty Pharmacy accreditation from URAC. Substantially all of the Company's mail service specialty mail order pharmacies also have been accredited by the Joint Commission, which is an independent, not-for-profit organization that accredits and certifies health care programs and organizations in the United States.

#### *Medicare Part D Services*

The Company participates in the administration of the Medicare Part D prescription drug program through the provision of PBM services to those health plan clients and other clients that have qualified as a PDP or as a Medicare Advantage prescription drug plan and by offering Medicare Part D pharmacy benefits through its SilverScript subsidiary that is a PDP that has contracted with the United States Centers for Medicare & Medicaid Services ("CMS"). The Company also assists employer, union and other health plan clients that qualify for the retiree drug subsidy made available under Medicare Part D by collecting and submitting eligibility and/or drug cost data to CMS in order for such clients to obtain the subsidy and offers Medicare Part D pharmacy benefits to such clients' retirees through Employer Group Waiver Plans ("EGWPs") sponsored by SilverScript.

#### *Clinical Services*

The Company offers multiple clinical programs and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner. These programs are primarily designed to promote better health outcomes, and to help target inappropriate medication utilization and non-adherence to medication, each of which may result in adverse medical events that negatively affect member health and client pharmacy and medical spend. These programs include utilization management ("UM"), medication management, quality assurance, adherence and counseling programs to complement the client's plan design and clinical strategies. To help address the opioid epidemic, the Company introduced an industry-leading UM approach that limits to seven days the supply of opioids dispensed for certain acute prescriptions for patients who are new to therapy; limits the daily dosage of opioids dispensed based on the strength of the opioid; and requires the use of immediate-release formulations of opioids before extended-release opioids are dispensed. The Company's Pharmacy Advisor program facilitates pharmacist counseling, both face-to-face and over the telephone, to help participating plan members with certain chronic diseases, such as diabetes and cardiovascular conditions, to identify gaps in care, adhere to their prescribed medications and manage their health conditions. The Company also has digital connectivity that helps to lower drug costs for patients by providing expanded visibility to lower cost alternatives through enhanced analytics and data sharing.

#### *Disease Management Programs*

The Company's clinical programs and services utilize advanced protocols and offer clients convenience in working with health care providers ("providers") and other third parties. The Company's integrated disease management programs cover diseases such as rheumatoid arthritis, Parkinson's disease, seizure disorders and multiple sclerosis. The majority of these integrated programs are accredited by the National Committee for Quality Assurance ("NCQA"), a private, not-for-profit organization that evaluates, accredits and certifies a wide range of health care organizations.

#### *Medical Benefit Management*

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

### ***Pharmacy Services Information Systems***

The majority of the Pharmacy Services segment's clients have migrated to a single claim adjudication platform. This platform incorporates architecture that centralizes the data generated from filling mail order prescriptions, adjudicating retail pharmacy claims and delivering other solutions to PBM clients. The Health Engagement Engine<sup>®</sup> technology and proprietary clinical algorithms help connect the various parts of the enterprise and serve an essential role in cost management and health improvement. This capability transforms pharmacy data into actionable interventions at key points of care such as mail and specialty pharmacists to help provide quality care.

### ***Pharmacy Services Clients***

The Company's Pharmacy Services clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D plans, Managed Medicaid plans and plans offered on public and private health insurance exchanges, other sponsors of health benefit plans and individuals located throughout the United States. Pharmaceuticals are provided to eligible members in benefit plans maintained by clients and utilize the Company's information systems, among other things, to help perform safety checks, drug interaction screening and identify opportunities for generic substitution. Substantially all of the Pharmacy Services segment's revenue is generated from dispensing and managing prescription drugs to eligible members in benefit plans maintained by clients. In 2018, 2017 and 2016, revenues from Aetna accounted for approximately 9.8%, 12.3% and 11.7%, respectively, of the Company's consolidated total revenues. On the Aetna Acquisition Date, Aetna became a wholly-owned subsidiary of CVS Health. Subsequent to the Aetna Acquisition Date, revenues from Aetna will continue to be reported in the Pharmacy Services segment; however, these revenues are eliminated in the consolidated financial statements.

### ***Pharmacy Services Seasonality***

The majority of Pharmacy Services segment revenues are not seasonal in nature. However, quarterly earnings and operating cash flows are impacted by the Medicare Part D benefit design and changes in the composition of PDP membership. The Medicare Part D standard benefit design results in coverage that varies with a member's cumulative annual out-of-pocket costs. The benefit design generally results in employers or other entities that sponsor the Company's products ("plan sponsors") sharing a greater portion of the responsibility for total prescription drug costs in the early part of the year. As a result, the PDP pay percentage or benefit ratio generally decreases and operating income generally increases as the year progresses.

### ***Pharmacy Services Competition***

The Company believes the primary competitive factors in the pharmacy services industry include: (i) the ability to negotiate favorable discounts from drug manufacturers as well as to negotiate favorable discounts from, and access to, retail pharmacy networks; (ii) the ability to identify and apply effective cost management programs utilizing clinical strategies, including the development and utilization of preferred formularies; (iii) the ability to market PBM products and services; (iv) the commitment to provide flexible, clinically-oriented services to clients and be responsive to clients' needs; (v) the quality, scope and costs of products and services offered to clients and their members; and (vi) operational excellence in delivering services. The Pharmacy Services segment has a significant number of competitors (e.g., the Express Scripts business of Cigna Corporation, OptumRx, Prime Therapeutics, MedImpact and Humana) offering PBM services, including large, national PBM companies, PBMs owned by large national health plans and smaller standalone PBMs. References to competitors and other companies throughout this Annual Report on Form 10-K, including the information incorporated by reference herein, are for illustrative or comparison purposes only and do not indicate that these companies are the Company's or any segment's only competitors or closest competitors.

### ***Retail/LTC Segment***

The Retail/LTC segment sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products, cosmetics and personal care products, provides health care services through its MinuteClinic<sup>®</sup> walk-in medical clinics and conducts long-term care ("LTC") pharmacy operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. Prior to January 2, 2018, the Retail/LTC segment also provided commercialization services under the name RxCrossroads<sup>®</sup>. The Company divested its RxCrossroads subsidiary on January 2, 2018. As of December 31, 2018, the Retail/LTC segment operated more than 9,900 retail locations, over 1,100 MinuteClinic<sup>®</sup> locations as well as online retail pharmacy websites, LTC pharmacies and onsite pharmacies. During the year ended December 31, 2018, the Retail/LTC segment filled approximately 1.3 billion prescriptions

on a 30-day equivalent basis. In December 2018, the Company held approximately 26% of the United States retail pharmacy market.

### ***Retail/LTC Products and Services***

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

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

	<b>Percentage of Revenues</b>		
	<b>2018</b>	<b>2017</b>	<b>2016</b>
Pharmacy <sup>(1)</sup>	76.4%	75.0%	75.0%
Front store and other <sup>(2)</sup>	23.6%	25.0%	25.0%
	<u>100.0%</u>	<u>100.0%</u>	<u>100.0%</u>

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

(2) "Other" represents less than 5% of the "Front store and other" revenue category.

### ***Pharmacy***

Pharmacy revenues represented approximately three-fourths of Retail/LTC segment revenues in each of 2018, 2017 and 2016. The Company believes that retail pharmacy operations will continue to represent a critical part of the Company's business due to industry demographics, e.g., an aging American population consuming a greater number of prescription drugs, prescription drugs being used more often as the first line of defense for managing illness, the introduction of new pharmaceutical products, and Medicare Part D growth. The Company believes the retail pharmacy business benefits from investment in both people and technology, as well as innovative collaborations with health plans, PBMs and providers. Given the nature of prescriptions, consumers want their prescriptions filled accurately by professional pharmacists using the latest tools and technology, and ready when promised. Consumers also need medication management programs and better information to help them get the most out of their health care dollars. To assist consumers with these needs, the Company has introduced integrated pharmacy health care services that provide an earlier, easier and more effective approach to engaging consumers in behaviors that can help lower costs, improve health and save lives.

### ***Front Store***

Front store revenues reflect the Company's strategy of innovating with new and unique products and services, using innovative personalized marketing and adjusting the mix of merchandise to match customers' needs and preferences. A key component of the front store strategy is the ExtraCare<sup>®</sup> 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<sup>®</sup> rewards and other benefits. The Company continues to launch and enhance new and exclusive brands to create unmatched offerings in beauty products and deliver other unique product offerings, including a full range of high-quality CVS Health and other proprietary brand products that are only available through CVS stores. The Company currently carries approximately 7,000 CVS Health and proprietary brand products, which accounted for approximately 23% of front store revenues during 2018.

### ***MinuteClinic***

As of December 31, 2018, the Company operated approximately 1,100 MinuteClinic<sup>®</sup> 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. Payers value these clinics because they provide convenient, high-quality, cost-effective care, in many cases offering an attractive alternative to more expensive sites of care. As a result, visits paid for by employers, health insurers or other third parties accounted for approximately 91% of MinuteClinic's total revenues in 2018. MinuteClinic is collaborating with the Pharmacy Services and Health Care Benefits segments to help meet the needs of CVS Caremark's client plan members and the Company's health plan members by offering programs that can improve member health and lower costs.

MinuteClinic is now affiliated with more than 75 major health systems and continues to build a platform that supports primary care.

#### *Long-term Care Pharmacy Operations*

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

#### *Onsite Pharmacies*

The Company also operates a limited number of pharmacies located at client sites, which provide certain health plan members and customers with a convenient alternative for filling their prescriptions.

#### ***Retail Store Development***

The addition of new retail locations has played, and will continue to play, a key role in the Company's continued growth and success. The Company's store development program focuses on three areas: entering new markets, adding stores within existing markets and relocating stores to more convenient sites. During 2018, the Company opened 145 new retail locations, relocated approximately 35 stores and closed approximately 30 locations. During the last five years, the Company opened approximately 900 new and relocated locations, and acquired approximately 1,825 locations, including the pharmacies acquired from Target Corporation ("Target") in 2015. The Company believes that continuing to grow its store base appropriately and locate retail stores in more accessible markets are essential components of competing effectively in the current health care environment. As a result, the Company believes that its store development program is an integral part of its ability to meet the needs of customers and maintain its leadership position in the retail pharmacy market given the changing health care landscape.

#### ***Retail/LTC Information Systems***

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

#### ***Retail/LTC Customers***

The success of the Retail/LTC segment's businesses is dependent upon the Company's ability to establish and maintain contractual relationships with pharmacy benefit managers and other payors on acceptable terms. Pharmacy benefit managers, managed care organizations, government funded health care programs, commercial employers and other third party payors accounted for 99.5% of the Retail/LTC segment's pharmacy revenues. No single Retail/LTC payor accounted for 10% or more of the Company's consolidated total revenues in 2018, 2017 or 2016.

#### ***Retail/LTC Seasonality***

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

## ***Retail/LTC Competition***

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

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

References to competitors and other companies throughout this Annual Report on Form 10-K, including the information incorporated by reference herein, are for illustrative or comparison purposes only and do not indicate that these companies are the Company's or any segment's only competitors or closest competitors.

## **Health Care Benefits Segment**

The Health Care Benefits segment is one of the nation's leading diversified health care benefits providers, serving an estimated 38 million people as of December 31, 2018. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make better informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services, workers' compensation administrative services and health information technology ("HIT") products and services. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers, governmental units, government-sponsored plans, labor groups and expatriates.

### ***Health Care Benefits Products and Services***

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

- *Commercial Medical:* The Health Care Benefits segment offers point-of-service ("POS"), preferred provider organization ("PPO"), health maintenance organization ("HMO") and indemnity benefit ("Indemnity") plans. Commercial medical products also include health savings accounts ("HSAs") and consumer-directed health plans that combine traditional POS or PPO and/or dental coverage, subject to a deductible, with an accumulating benefit account (which may be funded by the plan sponsor and/or the member in the case of HSAs). Principal products and services are targeted specifically to large multi-site national, mid-sized and small employers, individual insureds and expatriates. The Company offers medical stop loss insurance coverage for certain employers who elect to self-insure their health benefits. Under this product, the Company assumes risk for costs associated with large individual claims and/or aggregate loss experience within an employer's plan above a pre-set annual threshold.
- *Government Medical:* In select geographies, the Health Care Benefits segment offers Medicare Advantage plans, Medicare Supplement plans and prescription drug coverage for Medicare beneficiaries; participates in Medicaid and subsidized Children's Health Insurance Programs ("CHIP"); and participates in demonstration projects for members who are eligible for both Medicare and Medicaid ("Duals"). These Government Medical products are further described below:
  - *Medicare Advantage and PDP:* Through annual contracts with CMS, the Company offers HMO and PPO products for eligible individuals in certain geographic areas through the Medicare Advantage program. Members typically receive enhanced benefits over traditional fee-for-service Medicare coverage ("Original Medicare"), including reduced cost-sharing for preventive care, vision and other services. The Company offered network-based HMO and/or PPO plans in 1,317 counties in 40 states and Washington, D.C. in 2018. The Company has expanded to 1,416 counties in 45 states and Washington, D.C. for 2019. The Company is a national provider of drug benefits under the Medicare Part D prescription drug program to both individuals and EGWPs. All Medicare eligible individuals are eligible to participate in this voluntary prescription drug plan. Members typically receive

coverage for certain prescription drugs, usually subject to a deductible, co-insurance and/or co-payment. On November 30, 2018, Aetna completed the sale of all of its standalone Medicare Part D prescription drug plans to WellCare effective on December 31, 2018. Aetna will provide administrative services to, and retain the financial results of, the divested plans through 2019. For certain qualifying employer groups, the Company offers Medicare PPO products nationally. When combined with the Company's PDP product, these national PPO plans form an integrated national Insured Medicare product for employers that provides medical and pharmacy benefits.

- *Medicare Supplement:* For certain Medicare eligible members, the Company offers supplemental coverage for certain health care costs not covered by Original Medicare. The products included in the Medicare Supplement portfolio help to cover some of the gaps in Original Medicare, and include coverage for Medicare deductibles and coinsurance amounts. The Company offered a wide selection of Medicare Supplement products in 49 states and Washington, D.C. in 2018.
- *Medicaid and CHIP:* The Company offers health care management services to individuals eligible for Medicaid and CHIP under multi-year contracts with government agencies in various states that are subject to annual appropriations. CHIP are state-subsidized insurance programs that provide benefits for families with uninsured children. The Company offered these services on an Insured or ASC basis in 16 states in 2018.
- *Duals:* The Company provides health coverage to beneficiaries who are dually eligible for both Medicare and Medicaid coverage. These members must meet certain income and resource requirements in order to qualify for this coverage. The Company coordinates 100% of the care for these members and may provide them with additional services in order to manage their health care costs. During 2018, the Company offered services on an Insured basis to Duals in four states under demonstration projects.
- *Pharmacy:* The Company offers PBM services and specialty and home delivery pharmacy services. The Company also performs various PBM services for Aetna pharmacy customers consisting of: product development, Commercial formulary management, pharmacy rebate contracting and administration, sales and account management and precertification programs. The Pharmacy Services segment performs the administration of selected functions for retail pharmacy network contracting and claims administration; home delivery and specialty pharmacy order fulfillment and inventory purchasing and management; and certain administrative services. Other suppliers also provide certain PBM services.
- *Specialty:* The Health Care Benefits segment has a portfolio of additional health products and services that complement its medical products such as dental plans, behavioral health and employee assistance products, provider network access and vision products and workers' compensation administrative services.
- *Consumer Health Products and Services:* The Company has a portfolio of products and services aimed at creating a holistic and integrated approach to individual health and wellness. These products and services complement the Commercial Medical and Government Medical products and enable enhanced delivery to and experience for customers.

### ***Health Care Benefits Provider Networks***

The Company contracts with physicians, hospitals and other providers for services they provide to members. The Company uses a variety of techniques designed to help encourage appropriate utilization of medical services ("utilization") and maintain affordability of quality coverage. In addition to contracts with providers for negotiated rates of reimbursement, these techniques include creating risk sharing arrangements that align economic incentives with providers, the development and implementation of guidelines for the appropriate utilization of medical services and the provision of data to providers to enable them to improve health care quality. At December 31, 2018, the Company's underlying nationwide provider network had approximately 1.3 million participating providers, including over 697 thousand primary care and specialist physicians and approximately 5,700 hospitals. Other providers in the Company's provider networks also include laboratory, imaging, urgent care and other freestanding health facilities.

### ***Health Care Benefits Quality Assessment***

CMS uses a 5-star rating system to monitor Medicare health care and drug plans and ensure that they meet CMS's quality standards. CMS uses this rating system to provide Medicare beneficiaries with a tool that they can use to compare the overall quality of care and level of customer service of companies that provide Medicare health care and drug plans. The rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management and overall customer satisfaction. See "Health Care Benefits Pricing" below in this Item 1 for further discussion of star ratings. The Company seeks Health Plan accreditation for Aetna HMO plans from the NCQA. Health care plans seeking accreditation must pass a rigorous, comprehensive review and must annually report on their performance.

Aetna Life Insurance Company (“ALIC”), a wholly-owned subsidiary of the Company, has received nationwide NCQA PPO Health Plan accreditation. As of December 31, 2018, all of the Company’s Commercial HMO and all of ALIC’s PPO members who were eligible participated in HMOs or PPOs that are accredited by the NCQA.

The Company’s provider selection and credentialing/re-credentialing policies and procedures are consistent with NCQA and URAC, as well as state and federal, requirements. In addition, the Company is certified under the NCQA Credentials Verification Organization (“CVO”) certification program for all certification options and has URAC CVO accreditation.

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

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

### ***Health Care Benefits Information Systems***

The Health Care Benefits segment currently operates and supports an end to end suite of information technology platforms to support member engagement, enrollment, health benefit administration, care management, service operations, financial reporting and analytics. The multiple platforms are supported by an integration layer to facilitate the transfer of real-time data. There is continued focus and investment in digital products to offer innovative solutions and a seamless experience to the Company’s members through mobile and web channels. Capabilities available to members include digital wallet, provider search, cost transparency and behavioral monitoring. The Health Care Benefits segment care management solution supports the Company’s clinicians with data and recommendations. The Company continues to scale its clinical platform and its local personalized care model. The Company aims to build an integrated 360 degree view of the member to ensure that it can guide them through their healthcare journey and provide them a high level of service. Through its analytics platform the Company is beginning to harness the power of data to help drive healthier outcomes and proactive care and enable consumers to take the next best action for their health.

### ***Health Care Benefits Customers***

Medical membership is dispersed throughout the United States, and the Company also serves medical members in certain countries outside the United States. See Note 17 “Segment Reporting” contained in the “Notes to Consolidated Financial Statements” in the Annual Report, which is incorporated by reference herein, for additional information on foreign customers. The Company offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, many of which are available nationwide. Depending on the product, the Company markets to a range of customers including employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans, labor groups and expatriates.

The following table presents total medical membership by United States and other geographic region and funding arrangement at December 31, 2018:

<b><i><u>In thousands</u></i></b>	<b><u>Insured</u></b>	<b><u>ASC</u></b>	<b><u>Total</u></b>
Northeast	1,961	3,232	5,193
Southeast	1,752	2,886	4,638
Mid-America	1,632	2,530	4,162
West	1,618	4,510	6,128
Other	587	1,393	1,980
Total medical membership	<u>7,550</u>	<u>14,551</u>	<u>22,101</u>

For additional information on medical membership, see the caption “Management’s Discussion and Analysis of Financial Condition and Results of Operations — Health Care Benefits Segment” in the Annual Report, which section is incorporated by reference herein.

The Company markets both Commercial Insured and ASC products and services primarily to employers that sponsor the Company's products for the benefit of their employees and their employees' dependents. Frequently, larger employers offer employees a choice among coverage options, from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to the Company and, through payroll deductions, obtain reimbursement from employees for a percentage of the premiums that is determined by each employer. Some Health Care Benefits products are sold directly to employees of employer groups on a fully employee-funded basis. In some cases, the Company bills the covered individual directly.

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

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

The United States federal government is a significant customer of the Health Care Benefits segment through contracts with CMS for coverage of Medicare-eligible individuals, federal employee-related benefit programs and Medicaid products and services. Other than the contracts with CMS, the Health Care Benefits segment is not dependent upon a single customer or a few customers the loss of which would have a significant effect on the earnings of the segment. The loss of business from any one, or a few, independent brokers or agents would not have a material adverse effect on the earnings of the Health Care Benefits segment. For additional information, see Note 17 "Segment Reporting" contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

### ***Health Care Benefits Pricing***

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

Generally, a fixed premium rate is determined at the beginning of the policy period for Commercial Insured plans. The Company typically cannot recover unanticipated increases in health care and other benefit costs in the current policy period; however, it may consider prior experience for a product in the aggregate or for a specific customer, among other factors, in determining premium rates for future policy periods. Where required by state laws, premium rates are filed and approved by state regulators prior to contract inception. Future results of operations could be adversely affected if the premium rates requested are not approved or are adjusted downward or their approval is delayed by state or federal regulators.

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

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, the "ACA") ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star ratings." Since 2015, plans must have a star rating of four or higher (out of five) to qualify for a quality bonus in their basic premium rates. CMS released 2019

star ratings in October 2018. The 2019 star ratings will be used to determine which Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2020. Based on membership at December 31, 2018, 79% of the Company's Medicare Advantage members were in plans with 2019 star ratings of at least 4.0 stars.

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

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

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

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

Beginning in 2014, the ACA imposed significant new industry-wide fees, assessments and taxes, including an annual levy called the Health Insurer Fee (the "HIF"). In December 2015, the Consolidated Appropriation Act was enacted, which included a one year suspension of the HIF for 2017. In January 2018, the HIF was suspended for 2019. For additional information on the ACA fees, assessments and taxes, see Note 1 "Significant Accounting Policies" contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein. The Company's goal is to collect in premiums and fees where possible, or solve for all of these ACA-related fees, assessments and taxes.

### ***Health Care Benefits Seasonality***

The majority of Health Care Benefits segment revenues are not seasonal in nature. However, the Health Care Benefits segment's quarterly operating income progression is impacted by (i) the seasonality of benefit costs which generally increase during the year as Insured members progress through their annual deductibles and out-of-pocket expense limits and (ii) the seasonality of operating expenses which are generally the highest during the fourth quarter due to increased marketing spending associated with Medicare annual enrollment. As a result, the Health Care Benefits segment's operating income generally is the highest in the first quarter of the year and lowest in the fourth quarter of the year.

### ***Health Care Benefits Competition***

The health care benefits industry is highly competitive, primarily due to a large number of for-profit and not-for-profit competitors, competitors' marketing and pricing and a proliferation of competing products, including new products that are continually being introduced into the marketplace. New entrants into the marketplace, as well as consolidation within the industry, have contributed to and are expected to intensify the competitive environment. In addition, the rapid pace of change as the industry evolves towards a consumer-focused retail marketplace, including Public and Private Exchanges, and the increased use of technology to interact with members, providers and customers, increase the risks currently faced from new entrants and disruptive actions by existing competitors compared to prior periods. References to competitors and other companies throughout this Annual Report on Form 10-K, including the information incorporated by reference herein, are for illustrative or comparison purposes only and do not indicate that these companies are the Company's or any segment's only competitors or closest competitors.

The Company believes that the significant factors that distinguish competing health plans include the perceived overall quality (including accreditation status), quality of service, comprehensiveness of coverage, cost (including premium rates, provider discounts and member out-of-pocket costs), product design, financial stability and ratings, breadth and quality of

provider networks, ability to offer different provider network options, providers available in such networks, and quality of member support and care management programs. The Company believes that it is competitive on each of these factors. The Company's ability to increase the number of persons covered by its health plans or to increase Health Care Benefits segment revenues is affected by its ability to differentiate itself from its competitors on these factors. Competition may also affect the availability of services from health care providers, including primary care physicians, specialists and hospitals.

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

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

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

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

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

### ***Health Care Benefits Reinsurance***

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

### **Corporate/Other Segment**

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

- Management and administrative expenses to support the overall operations of the Company, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments; and
- Products for which the Company no longer solicits or accepts new customers such as large case pensions and long-term care insurance products.

## **Generic Sourcing Venture**

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

## **Working Capital Practices**

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

## **Colleague Development**

As of December 31, 2018, the Company employed approximately 295,000 colleagues in 50 states, the District of Columbia, Puerto Rico and a number of countries outside the United States. To deliver the highest levels of service to customers, the Company devotes considerable time and attention to its people and service standards. The Company emphasizes attracting and training knowledgeable, friendly and helpful associates to work in the organization.

## **Intellectual Property**

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

## **Government Regulation**

### ***Overview***

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

The laws and rules governing the Company’s businesses and interpretations of those laws and rules continue to expand and become more restrictive each year and are subject to frequent change. The application of these complex legal and regulatory requirements to the detailed operation of the Company’s businesses creates areas of uncertainty. Further, there are numerous proposed health care laws and regulations at the federal, state and international levels, some of which could adversely affect the Company’s businesses if they are enacted. The Company cannot predict whether pending or future federal or state legislation or

court proceedings, including future United States Congressional appropriations, will change various aspects of the industries in which it operates or the health care industry generally or the impact those changes will have on the Company's businesses, results of operations and/or cash flows, but the effects could be materially adverse. Any failure or alleged failure to comply with applicable laws and regulations as summarized below, or any adverse applications or interpretations of, or changes in, the laws and regulations affecting the Company and/or its businesses, could have a material adverse effect on the Company's results of operations, financial condition and/or cash flows. See Item 3, "Legal Proceedings" for further information.

The Company cannot give any assurances that its businesses, financial condition, results of operations and/or cash flows will not be materially adversely affected, or that it will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations, including the laws and regulations described in this Government Regulation section, as they may relate to one or more of the Company's businesses, one or more of the industries in which it operates and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's businesses, one or more of the industries in which it operates and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in other pending or future legal proceedings against the Company or affecting one or more of the industries in which it operates and/or the health care industry generally.

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

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

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

**The ACA** - The ACA made broad-based changes to the United States health care system. If the ACA is not further amended, repealed or replaced, certain of its components will continue to be phased in until 2022. While the Company anticipates continued efforts in 2019 and beyond to invalidate, modify, repeal or replace the ACA, the Company expects aspects of the ACA to continue to significantly impact its business operations and results of operations, including pricing, medical benefit ratios ("MBRs") and the geographies in which the Company's products are available.

While most of the significant aspects of the ACA became effective during or prior to 2014, parts of the ACA continue to evolve through the promulgation of executive orders, regulations and guidance as well as ongoing litigation. Additional changes to the ACA and those regulations and guidance at the federal and/or state level are likely, and those changes are likely to be significant. Growing federal and state budgetary pressures make it more likely that any changes, including changes at the state level in response to changes to, or invalidation, repeal or replacement of, the ACA and/or changes in the funding levels and/or payment mechanisms of federally supported benefit programs, will be adverse to us. For example, if any elements of the ACA are invalidated or repealed at the federal level, the Company expects that some states would seek to enact similar requirements, such as prohibiting pre-existing condition exclusions, prohibiting rescission of insurance coverage, requiring coverage for dependents up to age 26, requiring guaranteed renewability of insurance coverage and prohibiting lifetime limits on insurance coverage.

The expansion of health care coverage contemplated by the ACA is being funded in part by reductions to the reimbursements the Company and other health plans are paid by the federal government for Medicare members, among other sources. While not all-inclusive, the following are some of the key provisions of the ACA (assuming it continues to be implemented in its current form) that become effective on or after January 1, 2019. The Company continues to evaluate these provisions and the related regulations and regulatory guidance to determine the impact that they will have on its business operations and results of operations:

- The imposition on the Company and other health insurers, health plans and other market participants of significant fees, assessments and taxes, including an annual non-tax deductible industry-wide HIF that was \$14.3 billion for 2018 and has been suspended for 2019. As currently enacted, the HIF will apply for 2020, be higher for 2020 than for 2018 and increase in 2021 and annually thereafter.
- A non-tax deductible 40% excise tax on employer-sponsored health care benefits above a certain threshold beginning in 2022.
- Reduced funding for Medicaid expansion, which began in 2017.

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

Potential repeal of the ACA, ongoing legislative, regulatory and administrative policy changes to the ACA, the results of congressional and state level elections, the December 2018 U.S. District Court decision invalidating the ACA and other pending litigation challenging aspects of the law or funding for the law and federal budget negotiations continue to create uncertainty about the ultimate impact of the ACA. The pending litigation challenging the ACA includes challenges by various states of the federal government’s decision to curtail payments related to the Cost-Sharing Subsidy Program. The time frame for conclusion and final outcome and ultimate impact of this litigation are uncertain. Given the inherent difficulty of foreseeing the nature and scope of future changes to the ACA and how states, businesses and individuals will respond to those changes, the Company cannot predict the impact on it of future changes to the ACA. It is reasonably possible that invalidation, repeal or replacement of or other changes to the ACA and/or states’ responses to such changes, in the aggregate, could have a significant adverse effect on the Company’s businesses, results of operations and cash flows.

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

The Company continues to expand the number of counties in which it offers Medicare products. The Company expects to further expand its Medicare service area and products in 2019 and is seeking to substantially grow its Medicare membership, revenue and results of operations over the next several years, including through growth in Medicare Supplement products. The anticipated organic expansion of the Medicare service area and Medicare products offered and the Medicare-related provisions of the ACA significantly increase the Company’s exposure to funding and regulation of, and changes in government policy with respect to and/or funding or regulation of, the various Medicare programs in which the Company participates, including changes in the amounts payable to us under those programs and/or new reforms or surcharges on existing programs. For example, since the 2014 contract year, the ACA has required minimum MLRs for Medicare Advantage and Medicare Part D plans of 85%. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage contract pays rebates for five consecutive years, it will be terminated by CMS.

The Company’s Medicare Advantage and PDP products are heavily regulated by CMS. The regulations and contractual requirements applicable to the Company and other private participants in Medicare programs are complex, expensive to comply with and subject to change. For example, in the second quarter of 2014, CMS issued a final rule implementing the ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. The precise interpretation, impact and legality of this rule are not clear and are subject to pending litigation. Payments the Company receives from CMS for its Medicare Advantage and Part D businesses also are subject to risk adjustment based on the health status of the individuals enrolled. Elements of that risk adjustment mechanism continue to be challenged by the DOJ, the Office of Inspector General (“OIG”) and CMS itself. Substantial changes in the risk adjustment mechanism, including changes

that result from enforcement or audit actions, could materially affect the fairness of the Company's Medicare reimbursement, require the Company to raise prices or reduce the benefits offered to Medicare beneficiaries, and potentially limit the Company's (and the industry's) participation in the Medicare program.

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

CMS regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare Advantage and PDP beneficiaries. For example, CMS currently conducts risk adjustment data validation ("RADV") audits of a subset of Medicare Advantage contracts for each contract year. Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various years for RADV audit. The OIG also is auditing the Company's risk adjustment data and that of other companies, and the Company expects CMS and the OIG to continue auditing risk adjustment data. The Company also has received Civil Investigative Demands ("CIDs") from, and provided documents and information to, the Civil Division of the DOJ in connection with a current investigation of its patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

On October 26, 2018, CMS issued proposed rules related to, among other things, changes to the RADV audit methodology established by CMS in 2012, CMS projects that the changes to the RADV audit methodology would increase its recoveries from Medicare Advantage plans as a result of RADV audits. CMS has requested comments on the proposed rules, including whether the proposed RADV rule change should apply retroactively to audits of Medicare Advantage plans for contract year 2011 and forward. The Company is evaluating the potential adverse effect, which could be material, on the Company's results of operations, financial condition, and cash flows if the proposed RADV rule change were adopted as proposed. CMS also has announced its intent to use third party auditors to attain its ultimate goal of subjecting all Medicare Advantage contracts to either a comprehensive or a targeted RADV audit for each contract year.

A portion of each Medicare Advantage plan's reimbursement is tied to the plan's "star ratings." The star rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management, compliance and overall customer satisfaction. Only Medicare Advantage plans with an overall star rating of four or more stars (out of five stars) are eligible for a quality bonus in their basic premium rates. As a result, the Company's Medicare Advantage plans' results of operations in 2019 and going forward will be significantly affected by their star ratings. The Company's star ratings and past performance scores are adversely affected by the compliance issues that arise each year in its Medicare operations. CMS released the Company's 2019 star ratings in October 2018. The Company's 2019 star ratings will be used to determine which of its Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2020. Based on the Company's membership at December 31, 2018, 79% of its Medicare Advantage members were in plans with 2019 star ratings of at least 4.0 stars. CMS will release updated stars ratings in October 2019 that will be used to determine which Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2021. CMS also gives PDPs star ratings which affect PDP's enrollment and result in contract termination if the PDP is rated less than three stars for three consecutive years. CMS continues to revise its star ratings system to make it harder to achieve four stars or more. Despite the Company's success in maintaining high star ratings and other quality measures for 2019 and the continuation of its improvement efforts, there can be no assurances that it will be successful in maintaining or improving its star ratings in future years. Accordingly, the Company's Medicare Advantage plans may not be eligible for full level quality bonuses, which could adversely affect the benefits such plans can offer, reduce membership and/or reduce profit margins.

Overall, the Company projects the benchmark payment rates in CMS's April 2018 final notice detailing final Medicare Advantage benchmark payment rates for 2019 (the "Final Notice") will increase funding for the Company's Medicare Advantage business, excluding the impact of coding trend, by approximately 2.5 percent in 2019 compared to 2018. This 2019 rate increase only partially offsets the challenge the Company faces from the impact of the increasing cost of medical care (including prescription medications) and CMS local and national coverage decisions that require the Company to pay for services and supplies that are not factored into the Company's bids. The federal government may seek to impose restrictions on the configuration of pharmacy or other provider networks for Medicare Advantage and/or PDP plans, or otherwise restrict the ability of these plans to alter benefits, negotiate prices or establish other terms to improve affordability or maintain viability of products. The Company currently believes that the payments received and will receive in the near term are adequate to justify

the Company's continued participation in the Medicare Advantage and PDP programs, although there are economic and political pressures to continue to reduce spending on the program, and this outlook could change.

Going forward, the Company expects CMS, the OIG, the DOJ, other federal agencies and the United States Congress to continue to scrutinize closely each component of the Medicare program (including Medicare Advantage, PDP, demonstration projects such as Medicare-Medicaid plans and provider network access and adequacy), modify the terms and requirements of the program and possibly seek to recast or limit private insurers' role. It is not possible to predict the outcome of this Congressional or regulatory activity, any of which could adversely affect the Company.

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

**Antitrust and Unfair Competition** - The Federal Trade Commission ("FTC") investigates and prosecutes practices that are "unfair trade practices" or "unfair methods of competition." Numerous lawsuits have been filed throughout the United States against pharmaceutical manufacturers, retail pharmacies and/or PBMs under various federal and state antitrust and unfair competition laws challenging, among other things: (i) brand name drug pricing and rebate practices of pharmaceutical manufacturers, (ii) the maintenance of retail or specialty pharmacy networks by PBMs, and (iii) various other business practices of PBMs and retail pharmacies. To the extent that the Company appears to have actual or potential market power in a relevant market or CVS Pharmacy, CVS Specialty or MinuteClinic plays a unique or expanded role in a PBM or Health Care Benefits segment product offering, the Company's business arrangements and uses of confidential information may be subject to heightened scrutiny from an anti-competitive perspective and possible challenge by state or federal regulators or private parties.

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

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

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

personal health and financial information is used and the opportunity to “opt out” of certain disclosures before the insurer shares such information with a non-affiliated third party. Like HIPAA, GLBA sets a “floor” standard, allowing states to adopt more stringent requirements governing privacy protection. Complying with additional state requirements requires us to make additional investments beyond those the Company has made to comply with HIPAA and GLBA.

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

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

**Consumer Protection Laws** - The federal government has many consumer protection laws, such as the Federal Trade Commission Act, the Federal Postal Service Act, the Consumer Product Safety Act and the FTC’s Telemarketing Sales Rule. Most states also have similar consumer protection laws. In addition, the federal government and most states have adopted laws and/or regulations requiring places of public accommodation, health care services and other goods and services to be accessible to people with disabilities. These consumer protection and accessibility laws and regulations have been the basis for investigations, lawsuits and multistate settlements relating to, among other matters, the marketing of loyalty programs, and health care products and services, pricing accuracy, expired front store products, financial incentives provided by drug manufacturers to pharmacies in connection with therapeutic interchange programs, disclosures related to how personal data is used and protected and the accessibility of goods and services to people with disabilities. As a result of the Company’s direct-to-consumer activities, including mobile and web-based solutions offered to members and to other consumers, the Company also is subject to federal and state regulations applicable to electronic communications and to other general consumer protection laws and regulations. For example, the California Consumer Privacy Act will become effective in 2020, and the Company expects additional federal and state regulation of consumer privacy protection to be enacted in 2019. The Company expects these new laws and regulations to impact the design of its products and services and the management and operation of its businesses and to increase its compliance costs.

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

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

basis, can impose substantial fines and penalties, and may revoke the license, registration or program enrollment of a facility or professional.

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

PBM offerings of prescription drug coverage under certain risk arrangements may be subject to laws and regulations in various states. Such laws may require that the party at risk become licensed as an insurer, establish reserves or otherwise demonstrate financial viability. Laws that may apply in such cases include insurance laws and laws governing MCOs and limited prepaid health service plans.

The states of domicile of the Company's regulated subsidiaries have statutory risk-based capital, or "RBC", requirements for health and other insurance companies and HMOs based on the RBC Model Act. These RBC requirements are intended to assess the capital adequacy of life and health insurers and HMOs, taking into account the risk characteristics of a company's investments and products. The RBC Model Act sets forth the formula for calculating RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual company's business. In general, under these laws, an insurance company or HMO must submit a report of its RBC level to the insurance department or insurance commissioner of its state of domicile for each calendar year. At December 31, 2018, the RBC level of each of the Company's insurance and HMO subsidiaries was above the level that would require regulatory action.

For information regarding restrictions on certain payments of dividends or other distributions by the Company's HMO and insurance company subsidiaries, see Note 12 "Shareholders' Equity" contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

The holding company laws for the states of domicile of certain of the Company's subsidiaries also restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval (or an exemption), no person may acquire any voting security of an insurance holding company (such as the Company's parent company, CVS Health Corporation) that controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would control the insurance holding company. Control is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person.

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

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

**Environmental and Safety Regulation** - The Company's businesses are subject to various federal, state and local laws, regulations and other requirements pertaining to protection of the environment, public health and employee safety, including, for example, regulations governing the management of hazardous substances, the cleaning up of contaminated sites, and the maintenance of safe working conditions in the Company's stores, distribution centers and other facilities. Governmental agencies at the federal, state and local levels continue to focus on the retail and health care sectors' compliance with such laws

and regulations, and have at times pursued enforcement activities. Any failure to comply with these regulations could result in fines or other sanctions by government authorities.

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

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

In addition, ERISA generally preempts all state and local laws that relate to employee benefit plans, but the extent of the pre-emption continues to be reviewed by courts.

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

- Under the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012 significant, automatic across-the-board budget cuts (known as sequestration) began in March 2013, including Medicare spending cuts of not more than 2% of total program costs per year through 2024. Significant uncertainty remains as to whether and how the United States Congress will proceed with actions that create additional federal revenue and/or with entitlement reform. The Company cannot predict future federal Medicare or federal or state Medicaid funding levels or the impact that future federal or state budget actions or entitlement program reform, if it occurs, will have on the Company’s businesses, operations or results of operations, but the effects could be materially adverse, particularly on the Company’s Medicare and/or Medicaid revenues, MBRs and results of operations.
- The European Union’s (“EU’s”) General Data Protection Regulation (“GDPR”) began to apply across the EU during 2018.
- Other significant legislative and/or regulatory measures which are or recently have been under consideration include the following:
  - Elimination of the payment of manufacturer’s rebates on prescription drugs to PBMs, PDPs and Managed Medicaid organizations in connection with federally funded health care programs. In January 2019, HHS proposed regulations that would exclude such rebates from the safe harbor that currently is available for such payments under the federal anti-kickback statute.
  - Imposing requirements and restrictions on the design and/or administration of pharmacy benefits plans offered by the Company’s and its clients’ health plans and/or its PBM clients and/or the services the Company provides to those clients, including restricting or eliminating the use of formularies for prescription drugs; restricting the Company’s ability to require members to obtain drugs through a home delivery or specialty pharmacy; restricting the Company’s ability to place certain specialty or other drugs in the higher cost tiers of its pharmacy formularies; restricting the Company’s ability to make changes to drug formularies and/or clinical programs; limiting or eliminating rebates on pharmaceuticals; requiring the use of up front purchase price discounts on pharmaceuticals in lieu of rebates; restricting the Company’s ability to configure its health plan and retail pharmacy networks; and restricting or eliminating the use of certain drug pricing methodologies.
  - Increased federal or state government regulation of, or involvement in, the pricing and/or purchasing of drugs.

- Restricting the Company’s ability to limit providers’ participation in its networks and/or remove providers from its networks by imposing network adequacy requirements or otherwise (including in its Medicare and Commercial Health Care Benefits products).
- Imposing assessments on (or to be collected by) health plans or health carriers, which may or may not be passed onto their customers. These assessments may include assessments for insolvency, the uninsured, uncompensated care, Medicaid funding or defraying health care provider medical malpractice insurance costs.
- Mandating coverage by the Company and its clients’ health plans for additional conditions and/or specified procedures, drugs or devices (for example, high cost pharmaceuticals, experimental pharmaceuticals and oral chemotherapy regimens).
- Regulating electronic connectivity.
- Mandating or regulating the disclosure of provider fee schedules and other data about the Company’s payments to providers.
- Mandating or regulating disclosure of provider outcome and/or efficiency information.
- Prescribing or limiting members’ financial responsibility for health care or other covered services they utilize.
- Assessing the medical device status of HIT products and/or solutions, mobile consumer wellness tools and clinical decision support tools, which may require compliance with FDA requirements in relation to some of these products, solutions and/or tools.
- Imposing payment levels for services rendered to the Company’s members by providers who do not have contracts with the Company.
- Restricting the ability of employers and/or health plans to establish or impose member financial responsibility.
- Amending or supplementing ERISA to impose greater requirements on PBMs, the administration of employer-funded benefit plans or limit the scope of current ERISA pre-emption, which would among other things expose us and other health plans to expanded liability for punitive and other extra-contractual damages and additional state regulation.

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

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

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

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

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

**Federal Employee Health Benefits Program** - The Company’s subsidiaries contract with the Office of Personnel Management (the “OPM”) to provide managed health care services under the FEHB program in their service areas. These contracts with the

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

**Disease Management Services Regulation** - The Company provides disease management programs to health plan and PBM plan members for complex medical conditions and arranges for those members to receive disease management programs for common medical conditions. State laws regulate the practice of medicine, the practice of pharmacy and the practice of nursing. Clinicians engaged in a professional practice in connection with the provision of disease management services must satisfy applicable state licensing requirements and must act within their scope of practice.

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

**International Regulation** - The Company currently has insurance licenses in several foreign jurisdictions and does business directly or through local affiliations in numerous countries around the world. The Company is taking steps to be able to continue to serve customers in the European Economic Area following the United Kingdom’s pending exit from the EU (“Brexit”). However, the impact of Brexit on the Company’s international business and results of operations is uncertain.

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

**Anti-Corruption Laws** - The FCPA prohibits offering, promising or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. The Company also is subject to applicable anti-corruption laws of the jurisdictions in which it operates. In many countries outside the United States, health care professionals are employed by the government. Therefore, the Company’s dealings with them are subject to regulation under the FCPA. Violations of the FCPA and other anti-corruption laws may result in severe criminal and civil sanctions as well as other penalties, and the United States Securities and Exchange Commission (the “SEC”) and the DOJ have increased their enforcement activities with respect to the FCPA. The UK Bribery Act is an anti-corruption law that is broader in scope than the FCPA and applies to all companies with a nexus to the United Kingdom. Disclosures of FCPA violations may be shared with the UK authorities, thus potentially exposing companies to liability and potential penalties in multiple jurisdictions. The Company has internal control policies and procedures and conducts training and compliance programs for its employees to deter prohibited practices. However, if the Company’s employees or agents fail to comply with applicable laws governing its international operations, it may face investigations, prosecutions and other legal proceedings and actions which could result in civil penalties, administrative remedies and criminal sanctions.

**Anti-Money Laundering Regulations** - Certain lines of the Company’s businesses are subject to Treasury anti-money laundering regulations. Those lines of business have implemented anti-money laundering policies designed to insure their

compliance with the regulations. The Company also may be subject to anti-money laundering laws in non-U.S. jurisdictions where it operates.

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

### ***Laws and Regulations Related to the Pharmacy Services Segment***

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

**PBM Laws and Regulation** - Legislation seeking to regulate PBM activities in a comprehensive manner has been introduced or enacted in a number of states. This legislation could adversely affect the Company's ability to conduct business on commercially reasonable terms in states where the legislation is in effect. In addition, certain quasi-regulatory organizations, including the National Association of Boards of Pharmacy and the National Association of Insurance Commissioners ("NAIC") and the National Council of Insurance Legislators, have issued model regulations or may propose future regulations concerning PBMs and/or PBM activities. Similarly, credentialing organizations such as NCQA and URAC may establish voluntary standards regarding PBM, mail or specialty pharmacy activities. While the actions of these quasi-regulatory or standard-setting organizations do not have the force of law, they may influence states to adopt their requirements or recommendations and influence client requirements for PBM or specialty pharmacy services. Moreover, any standards established by these organizations could also impact the Company's health plan clients and/or the services provided to them and/or the Company's health plans.

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

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

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

**Pharmacy Pricing Legislation** - Several states have passed legislation regulating the Company's ability to manage and establish MACs for generic prescription drugs. MAC methodology is a common cost management practice used by private and public payors (including CMS) to pay pharmacies for dispensing generic prescription drugs. MAC prices specify the allowable reimbursement by a PBM for a particular strength and dosage of a generic drug that is available from multiple manufacturers but sold at different prices. State legislation can regulate the disclosure of MAC prices and MAC price methodologies, the kinds of drugs that a PBM can pay for at a MAC price, and the rights of pharmacies to appeal a MAC price established by a PBM. These laws could negatively affect the Company's ability to establish MAC prices for generic drugs.

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

**FDA Regulation** - The FDA regulates the Company's compounding pharmacy and clinical research operations.

#### ***Laws and Regulations Related to the Retail/LTC Segment***

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

**FDA Regulation** - The FDA generally has authority to, among other things, regulate the manufacture, distribution, sale and labeling of many products sold through retail pharmacies, including prescription drugs, over-the-counter medications, medical devices (including mobile medical devices), cosmetics, dietary supplements and certain food items. The FDA regulates the Company's activities as a distributor of store brand products.

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

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

#### ***Laws and Regulations Related to the Health Care Benefits Segment***

**Overview** - Differing approaches to state insurance regulation and varying enforcement philosophies may materially and adversely affect the Company's ability to standardize its Health Care Benefits products and services across state lines. These laws and regulations, including the ACA, restrict how the Company conducts its business and result in additional burdens and costs to the Company. Significant areas of governmental regulation include premium rates and rating methodologies, underwriting rules and procedures, required benefits, sales and marketing activities, provider rates of payment, restrictions on health plans' ability to limit providers' participation in their networks and/or remove providers from their networks and financial condition (including reserves and minimum capital or risk based capital requirements). These laws and regulations are different in each jurisdiction and vary from product to product.

Each health insurer and HMO must file periodic financial and operating reports with the states in which it does business. In addition, health insurers and HMOs are subject to state examination and periodic license renewal. Applicable laws also restrict the ability of the Company's regulated subsidiaries to pay dividends, and certain dividends require prior regulatory approval. In

addition, some of the Company's businesses and related activities may be subject to PPO, managed care organization, utilization review or TPA-related licensure requirements and regulations. These licensure requirements and regulations differ from state to state, but may contain provider network, contracting, product and rate, financial and reporting requirements. There also are laws and regulations that set specific standards for the Company's delivery of services, payment of claims, fraud prevention, protection of consumer health information, and payment for covered benefits and services.

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

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

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

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

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

The ACA also specifies minimum MLRs of 85% for large group Commercial products and 80% for individual and small group Commercial products. Because the ACA minimum MLRs are structured as "floors" for many of their requirements, states have the latitude to enact more stringent rules governing its various restrictions. For Commercial products, states have and may adopt higher minimum MLR requirements, use more stringent definitions of "medical loss ratio," incorporate minimum MLR requirements into prospective premium rate filings, require prior approval of premium rates or impose other requirements related to minimum MLR. Minimum MLR requirements and similar actions further limit the level of margin the Company can

earn in its Insured Commercial business while leaving the Company exposed to medical costs that are higher than those reflected in its pricing. The Company also may be subject to significant fines, penalties, premium refunds and litigation if it fails to comply with minimum MLR laws and regulations.

In addition, the Company requested significant increases in its premium rates in its Commercial small group Health Care Benefits business for 2019 and expects to continue to request significant increases in those rates for 2020 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and significant assessments, fees and taxes imposed by the federal and state governments, including the ACA. The Company's rates also must be adequate to reflect adverse selection in its products, particularly in small group Commercial products, which the Company expects to continue and potentially worsen in 2019. These significant rate increases heighten the risks of adverse public and regulatory action and adverse selection and the likelihood that the Company's requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

Many of the laws and regulations governing the Company's pricing and underwriting practices also limit the differentials in premium rates insurers and other carriers may charge between new and renewal business, and/or between groups based on differing characteristics. They may also require that carriers disclose to customers the basis on which the carrier establishes new business and renewal premium rates and limit the ability of a carrier to terminate customers' coverage. In addition, HHS' rules on rates impose additional public disclosure requirements on any rate filings that exceed the "reasonableness" threshold and require additional review of those rates.

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

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

The impact of Medicaid expansion under the ACA is uncertain. The future of the ACA is uncertain, and states may opt out of the elements of the ACA requiring expansion of Medicaid coverage without losing their current federal Medicaid funding. To date, a number of states and the District of Columbia have expanded Medicaid coverage to the higher eligibility levels contemplated by the ACA. In addition, the election of new governors and/or state legislatures may impact states' previous decisions regarding Medicaid expansion. Proposals for substantial changes to federal funding of state Medicaid programs are likely to be considered in 2019 and beyond, including the possibility of converting federal Medicaid support to block grants and per capita caps on federal funding. Uncertainty regarding federal funding is causing and will continue to cause states to re-evaluate their Medicaid expansions and consider new assessments, fees and/or taxes on health plans. That re-evaluation may adversely affect Medicaid payment rates, the Company's revenues and its Medicaid membership in those states.

The economic aspects of the Medicaid, dual eligible and dual eligible special needs plan business vary from state to state and are subject to frequent change. Medicaid premiums are paid by each state and differ from state to state. The federal government and certain states also are considering proposals and legislation for Medicaid and dual eligible program reforms or redesigns, including restrictions on the collection of manufacturer's rebates on pharmaceuticals by Medicaid MCOs and their contracted PBMs, further program, population and/or geographic expansions of risk-based managed care, increasing beneficiary cost-sharing or payment levels, and changes to benefits, reimbursement, eligibility criteria, provider network adequacy requirements (including requiring the inclusion of specified high cost providers in the Company's networks) and program structure. In some states, current Medicaid and dual eligible funding and premium revenue may not be adequate for the Company to continue program participation. The Company's Medicaid and dual eligible contracts with states (or sponsors of Medicaid managed care plans) are subject to cancellation by the state (or the sponsors of the managed care plans) after a short notice period without cause (for example, when a state discontinues a managed care program) or in the event of insufficient state funding.

The Company's Medicaid, dual eligible and dual eligible special needs plan products also are heavily regulated by CMS and state Medicaid agencies, which have the right to audit the Company's performance to determine compliance with CMS

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

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

**State Workers' Compensation Laws** - The Company's workers' compensation business includes the comparison of medical claims data against the applicable state's fee schedule pricing, including applicable regulations and clinical guidelines. State fee schedules, which typically represent the maximum reimbursement for medical services provided to the injured worker, differ by state and change as state laws and regulations are passed and/or amended. The Company's workers' compensation business also includes PBM and care management services, both of which are regulated at the state level. The Company's workers' compensation customers include insurance carriers and TPAs who also are regulated at the state level. The laws and regulations applicable to the Company and other participants in the workers' compensation business are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and its workers' compensation compliance efforts will continue to require significant resources. The Company may be subject to significant fines, penalties and litigation if it fails to comply with those laws and regulations.

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

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

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

#### **Available Information**

CVS Health Corporation was incorporated in Delaware in 1996. The corporate office is located at One CVS Drive, Woonsocket, Rhode Island 02895, telephone (401) 765-1500. The Company's common stock is listed on the New York Stock

Exchange under the trading symbol “CVS.” General information about CVS Health is available through the Company’s website at <http://www.cvshealth.com>. The Company’s financial press releases and filings with the SEC are available free of charge within the Investors section of the Company’s website at <http://www.cvshealth.com/investors>. In addition, the SEC maintains an internet site that contains reports, proxy and information statements and other information regarding issuers, such as the Company, that file electronically with the SEC. The address of that website is <http://www.sec.gov>. The information on or linked to the Company’s website is neither a part of nor incorporated by reference in this Annual Report on Form 10-K or any of the Company’s other SEC filings.

In accordance with guidance provided by the SEC regarding use by a company of its websites and social media channels as a means to disclose material information to investors and to comply with its disclosure obligations under Regulation FD, CVS Health Corporation (the “Registrant”) hereby notifies investors, the media and other interested parties that it intends to continue to use its media and investor relations website (<http://investors.cvshealth.com/>) and its Twitter feed (@CVSHealthIR) to publish important information about the Registrant, including information that may be deemed material to investors. The list of social media channels that the Registrant uses may be updated on its media and investor relations website from time to time. The Registrant encourages investors, the media, and other interested parties to review the information the Registrant posts on its website and social media channels as described above, in addition to information announced by the Registrant through its SEC filings, press releases and public conference calls and webcasts.

## **Item 1A. Risk Factors**

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

If any of the following risks or uncertainties develops into actual events or if the circumstances described in the risks or uncertainties occur or continue to occur, these events or circumstances could have a material adverse effect on our businesses, results of operations, cash flows and/or financial condition. In that case, our stock price could decline materially, among other effects on us. You should read the following section in conjunction with “Management’s Discussion and Analysis of Financial Condition and Results of Operations” (which includes our “Cautionary Statement Concerning Forward-Looking Statements” at the end of such section) in the Annual Report, which is incorporated by reference herein, and our consolidated financial statements and the related notes.

### **Overarching Risks**

***Risks to our brand and reputation, the Aetna Acquisition, data governance risks, effectiveness of our talent management and alignment of talent to our business needs, and potential changes in public policy, laws and regulations present overarching risks to our enterprise in 2019 and beyond.***

We expect to face significant business challenges and uncertainties in 2019. Risks to our brand and reputation, the Aetna Acquisition, data governance risks, effectiveness of our talent management and alignment of talent to our business needs, and potential changes in public policy, laws and regulations present overarching risks to our enterprise in 2019 and beyond. There can be no assurance regarding our ability to avoid harm to our brand and reputation, our ability to manage the risks inherent in the Aetna Acquisition or our data governance risks, our ability to manage and align our talent to our business needs or our ability to manage the risks presented by changes in public policy, laws or regulations. In addition, there can be no assurance that the Aetna Acquisition, United States government fiscal policy, changes to the United States health care system (including changes to the ACA, to drug reimbursement and/or drug pricing laws and regulations and/or to laws and regulations governing PBMs’ interactions with government funded health care programs) or other unanticipated risks will not require us to revise the ways in which we conduct business, put us at risk of loss of business or materially adversely affect our businesses, cash flows, financial condition or results of operations.

***Our brand and reputation are two of our most important assets; negative public perception of the industries in which we operate, or of our industries' or our practices, can adversely affect our businesses, results of operations, cash flows and prospects.***

Reputational risk is inherent in many of the risks we face. The industries in which we operate regularly are negatively perceived by the public and subject to negative publicity, including as a result of adverse media coverage, litigation against us and other industry participants, the ongoing public debates over drug pricing, government involvement in drug pricing and purchasing, PBMs and the future of the ACA, governmental hearings and/or investigations and actual or perceived shortfalls regarding our industries' or our own products and/or business practices (including PBM operations, drug pricing, insurance coverage determinations and social media and other media relations activities). This risk may be increased as the federal government continues to consider increased involvement in drug reimbursement, pricing and/or purchasing and changes to the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, and as states seek to maintain, replace or repeal elements of the ACA such as Public Exchanges and Medicaid expansion within increasingly challenging budget constraints. This risk also may be increased as we continue to offer products and services that make greater use of data and as our business model becomes more focused on delivering health care to consumers. Significant reductions or interruptions in funding for government health programs we serve also may lead us to reduce our exposure to these programs, which could adversely affect our brand and reputation.

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

- Adversely affecting our brand and reputation;
- Adversely affecting our ability to market and sell our products and/or services and/or retain our existing customers and members;
- Requiring us to change our products and/or services;
- Reducing or restricting the compensation we can receive for our products and/or services; and/or
- Increasing or significantly changing the regulatory and legislative requirements with which we must comply.

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

Our information systems are critical to the operation of our businesses. We collect, process, maintain, retain, evaluate, utilize and distribute large amounts of personal health and financial information and other confidential and sensitive data about our customers, members and other constituents in the ordinary course of our businesses. Some of our information systems rely upon third party systems to accomplish these tasks. The use and disclosure of such information is regulated at the federal, state and international levels, and these laws, rules and regulations are subject to change and increased enforcement activity, such as the EU's GDPR which began to apply across the EU during 2018 and the audit program implemented by HHS under HIPAA. In some cases, such laws, rules and regulations also apply to our vendors and/or may hold us liable for any violations by our vendors. International laws, rules and regulations governing the use and disclosure of such information are generally more stringent than in the United States, and they vary from jurisdiction to jurisdiction. Noncompliance with any privacy or security laws or regulations, or any security breach, cyber-attack or cybersecurity breach, and any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, sensitive or confidential member, customer or other constituent information, whether by us, by one of our vendors or by another third party, could require us to expend significant resources to remediate any damage, interrupt our operations and damage our brand and reputation, and could also result in investigations, regulatory enforcement actions, material fines and penalties, loss of customers, litigation or other actions which could have a material adverse effect on our brand, reputation, businesses, results of operations and cash flows.

Our businesses depend on our customers' and members' willingness to entrust us with their health related and other sensitive personal information. Events that adversely affect that trust, including inadequate disclosure to our members or customers of our uses of their information, failing to keep our information technology systems and our members', customers' and other constituents' sensitive information secure from significant attack, theft, damage, loss or unauthorized disclosure or access, whether as a result of our action or inaction or that of our business associates, vendors or other third parties, could adversely affect our brand and reputation, membership and results of operations and also can and/or has exposed us to mandatory disclosure to the media, litigation (including class action litigation), governmental investigations and enforcement proceedings,

material fines, penalties and/or remediation costs, and compensatory, special, punitive and statutory damages, consent orders, adverse actions against our licenses to do business and/or injunctive relief, any of which could adversely affect our businesses, cash flows, results of operations or financial condition. Large scale data breaches at other entities increase the challenge we and our vendors face in maintaining the security of our information technology systems and of our customers', members' and other constituents' sensitive information. There can be no assurance that additional such failures will not occur, or if any do occur, that we will detect them or that they can be sufficiently remediated.

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

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

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

***We are subject to potential changes in public policy, laws and regulations, including reform of the United States health care system, that can adversely affect the markets for our products and services and our businesses, operations, results of operations, cash flows and prospects.***

The political environment in which we operate remains uncertain. It is reasonably possible that our business operations and results of operations could be materially adversely affected by legislative, regulatory and public policy changes at the federal or state level, increased government involvement in drug reimbursement, pricing and/or purchasing, increased regulation of PBMs, changes to Medicare, Medicaid or the regulatory environment for health care benefits, including the ACA, changes to drug reimbursement and/or pricing laws and regulations, changes to the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, changes to immigration policies and/or many other public policy initiatives. For example, in January 2019, HHS proposed regulations that would exclude from the current safe harbor under the federal anti-kickback statute manufacturer's rebates on prescription drugs paid to PBMs, PDPs and Managed Medicaid organizations in connection with federally funded health care programs. It is not possible to predict whether or when any such changes will occur or what form any such changes may take (including through the use of United States Presidential Executive Orders). Other significant changes to health care system legislation or regulation as well as changes with respect to tax and trade policies, tariffs and other government regulations affecting trade between the United States and other countries are also possible and could adversely affect us. If we fail to respond adequately to such changes, including by implementing strategic and operational initiatives, or do not do so as effectively as our competitors, our businesses, operations and results of operations may be materially adversely affected.

In addition to efforts to amend, repeal or replace the ACA and related regulations, we expect the federal and state governments to continue to enact and seriously consider many broad-based legislative and regulatory proposals that will or could materially impact various aspects of the health care and related benefits system and our businesses. Potential modification to the ACA, including changes in enforcement and/or funding that further destabilize the Public Exchanges, as well as significant changes to Medicaid funding could impact the number of Americans with health insurance and, consequently, prescription drug coverage. Further changes to federal health care laws, including the ACA, drug reimbursement and pricing laws and/or laws governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, are probable. We cannot predict the effect, if any, that new health care legislation, future changes to the ACA or the implementation or failure to implement the outstanding provisions of ACA, may have on our retail pharmacy, LTC pharmacy, specialty pharmacy, pharmacy services and/or Health Care Benefits operations and/or results of operations. The federal and many state governments also are considering changes in the interpretation, enforcement and/or application of existing programs, laws and regulations, including changes to payments under and funding of Medicare and Medicaid programs.

In addition, much of the branded and generic drug product that we sell in our retail, mail and specialty pharmacies, and much of the other merchandise we sell, is manufactured in whole or in substantial part outside of the United States. In most cases, the products or merchandise are imported by others and sold to us. As a result, significant changes in tax or trade policies, tariffs or trade relations between the United States and other countries, such as the imposition of unilateral tariffs on imported products, could result in significant increases in our costs, restrict our access to suppliers, depress economic activity, and have a material

adverse effect on our businesses, cash flows and results of operations. In addition, other countries may change their business and trade policies and such changes, as well as any negative sentiments towards the United States in response to increased import tariffs and other changes in United States trade regulations, could adversely affect our businesses.

We cannot predict the enactment or content of new legislation and regulations or changes to existing laws or regulations or their enforcement, interpretation or application, or the effect they will have on our business operations or results of operations, which could be materially adverse. Even if we could predict such matters, it is not possible to eliminate the adverse impact of public policy changes that would fundamentally change the dynamics of one or more of the industries in which we operate. Examples of such change include: the federal or one or more state governments fundamentally restructuring or reducing the funding available for Medicare, Medicaid, dual eligible or dual eligible special needs plan programs, increasing its involvement in drug reimbursement, pricing and/or purchasing, changing the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, changing the tax treatment of health or related benefits, or repealing or otherwise significantly altering the ACA. The likelihood of adverse changes remains high due to state and federal budgetary pressures, and our businesses and results of operations could be materially and adversely affected by such changes, even if we correctly predict their occurrence. For more information on these matters, see "Government Regulation" included in Item 1 of this Annual Report on Form 10-K.

***Our enterprise strategy may not be an effective response to the changing dynamics in the industries in which we operate, or we may not be able to implement our strategy and related strategic projects.***

Our strategy includes effectively investing our capital and human resources in appropriate strategic projects, current operations and acquisitions to transform our businesses in response to the changing dynamics in the industries in which we operate. Our strategic projects include, among other things: integrating the Aetna Acquisition; significant investments in human and technology resources to expand our consumer-oriented products and services; optimizing our business platforms; managing certain significant technology projects; further improving relations with manufacturers, suppliers and health care providers; negotiating contract changes with customers, manufacturers, suppliers and health care providers and implementing other business process improvements. Implementing our strategic initiatives will require significant investments of capital and human resources. Among other things, we will need to simultaneously acquire and develop new personnel, products and systems to serve existing and new customers with existing and new products and to enhance our existing customer service, information technology, control and compliance processes and systems. The future performance of our businesses will depend in large part on our ability to design and implement our strategic initiatives, some of which will occur over several years. If these initiatives do not achieve their objectives, our results of operations could be adversely affected.

Our enterprise strategy may not be an effective response to the changing dynamics in the industries in which we operate, and we may fail to recognize and position ourselves to capitalize upon market opportunities. We may not have sufficient advance notice and resources to develop and effectively implement an alternative strategy. If our existing competitors and/or new entrants (whether vertical, horizontal or online/digital/e-commerce) into one or more of our businesses create new disruptive business models and/or develop new offerings that customers, members and/or health care providers prefer to our offerings, we may lose customers, members and/or providers, and our results of operations, cash flows and/or prospects may be adversely affected. In addition, our results of operations, cash flows and/or prospects may be adversely affected by consolidation among the participants in the industries in which we operate and/or our customer base. Our businesses and results of operations could be materially and adversely affected by such changes, even if we correctly predict their occurrence.

## **Risks Related to Our Businesses**

***Efforts to reduce reimbursement levels and alter health care financing practices could adversely affect our businesses.***

The continued efforts of HMOs, MCOs, PBMs, government entities, and other third party payors to reduce prescription drug costs and pharmacy reimbursement rates, as well as litigation and other legal proceedings relating to how drugs are priced, may adversely affect our profitability. In particular, increased utilization of generic drugs (which normally yield a higher gross profit rate than equivalent brand named drugs) has resulted in pressure to decrease reimbursement payments to retail, specialty, LTC and mail order pharmacies for generic drugs, causing a reduction in our margins on sales of generic drugs. Historically, the effect of this trend on generic profitability has been mitigated by the introduction of new multi-source generic drugs as well as inflation on brand name drugs and by our efforts to negotiate reduced acquisition costs of generic drugs with manufacturers. However, in recent years, there has been significant consolidation within the generic manufacturing industry and in 2019 we expect fewer new multi-source generic drugs to be introduced and lower brand name drug inflation than in recent prior years, and it is possible that these and other external factors may enhance the ability of manufacturers to sustain or increase pricing of generic drugs and diminish our ability to negotiate reduced acquisition costs. Any inability to offset increased brand name or

generic prescription drug costs or to modify our activities to lessen the financial impact of such increased costs could have a significant adverse effect on our results of operations.

In addition, during the past several years, the United States health care industry has been subject to an increase in governmental regulation and audits at both the federal and state levels. Efforts to control health care costs, including prescription drug costs, are continuing at the federal and state government levels. Changing political, economic and regulatory influences may significantly affect health care financing and reimbursement practices. For example, we anticipate that federal and state governments will continue to review and assess alternative health care delivery systems, payment methodologies and operational requirements for health care providers, including LTC facilities and pharmacies, and participants in government funded health care programs. A change in the composition of pharmacy prescription volume toward programs offering lower reimbursement rates could adversely affect our profitability. Any action taken to repeal or replace all or significant parts of ACA also could adversely affect our profitability, though it is unclear at this time what the full effects of any such changes would be.

The ACA made several significant changes to Medicaid rebates and to reimbursement rates. One of these changes was to revise the definition of the Average Manufacturer Price, a pricing element common to most payment formulas, and the reimbursement formula for generic drugs. This change has adversely affected the reimbursements we receive when we dispense prescription drugs to Medicaid recipients. In addition, the ACA made other changes that affect the coverage and plan designs that are or will be provided by many of our health plan clients, including the requirement for health insurers to meet a minimum MLR to avoid having to pay rebates to enrollees. These ACA changes may not affect our businesses directly, but they could indirectly impact our services, business practices and/or results of operations.

***Gross margins in the industries in which we operate may decline.***

The PBM industry has been experiencing margin pressure as a result of competitive pressures and increased client demands for lower prices, increased revenue sharing, enhanced service offerings and/or higher service levels. In that regard, we maintain contractual relationships with generic drug manufacturers and brand name drug manufacturers that provide for purchase discounts and/or rebates on drugs dispensed by pharmacies in our retail network and by our specialty and mail order pharmacies (all or a portion of which may be passed on to clients). Manufacturer's rebates often depend on a PBM's ability to meet contractual market share or other requirements, including in some cases the placement of a manufacturer's products on the PBM's formularies. If we lose our relationship with one or more drug manufacturers, or if the discounts or rebates provided by drug manufacturers decline, our businesses and results of operations could be adversely affected. Further, competitive pressures in the PBM industry have resulted in our clients sharing in a larger portion of rebates and/or discounts received from drug manufacturers. Marketplace dynamics and regulatory changes also have impacted our ability to offer plan sponsors pricing that includes the use of retail "differential" or "spread", which could adversely affect our future profitability, and we expect these trends to continue. Further, changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to additional regulation of PBMs, drug pricing or purchasing, patent term extensions, purchase discount and/or rebate arrangements with drug manufacturers, or additional regulation of PBMs, formulary management or other PBM services could also reduce the discounts or rebates we receive. In addition, changes in federal or state laws or regulations or the adoption of new laws or regulations relating to claims processing and billing, including our ability to use MAC lists and collect transmission fees, could adversely affect our profitability.

Our retail pharmacy, specialty pharmacy and LTC pharmacy operations also have been affected by the margin pressures described above, including client demands for lower prices, generic pricing and network reimbursement pressure. In addition, as competition increases in the geographies in which we operate, including competition from new entrants, a significant increase in general pricing pressures could occur, and this could require us to reevaluate our pricing structures to remain competitive. A shift in the mix of our pharmacy prescription volume towards programs offering lower reimbursement rates could adversely affect our margins, including the ongoing shift in pharmacy mix towards 90-day prescriptions at retail and the ongoing shift in pharmacy mix towards Medicare Part D prescriptions. Finally, the margins of our LTC business are further affected by the increased efforts of health care payors to negotiate reduced or capitated pricing arrangements. These actions could also adversely affect the margins of our LTC business.

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

Our businesses are affected by the United States economy and consumer confidence in general and in the geographies we serve, including various economic factors, inflation and changes in consumer purchasing power, preferences and/or spending patterns. It is possible that an unfavorable, uncertain or volatile economic environment will cause a decline in drug utilization, an increase in health care utilization and dampen demand for PBM services as well as consumer demand for products sold in our retail stores. Further, economic conditions including interest rate fluctuations, changes in capital market conditions and

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

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

***We operate in a highly competitive business environment. Competitive and economic pressures may limit our ability to increase pricing to reflect higher costs or may force us to accept lower margins. If customers elect to self-insure, reduce benefits or adversely renegotiate or amend their agreements with us, our revenues and results of operations will be adversely affected. We may not be able to obtain appropriate pricing on new or renewal business.***

Each of our businesses currently operates in a highly competitive and evolving business environment. We must compete successfully with existing competitors and new entrants, including strategic alliances and online, digital and e-commerce companies.

The competitive success of our retail pharmacy business, as well as our specialty pharmacy operations with third-party payors, is dependent on our ability to establish and maintain contractual relationships with PBMs and other payors on acceptable terms in an environment where some PBM clients are considering adopting narrow or restricted retail pharmacy networks. As a pharmacy retail business, we compete with other drugstore chains, supermarkets, online and other discount retailers, independent pharmacies, membership clubs, convenience stores and mass merchants, some of which are aggressively expanding into markets we serve. We also face competition from other retail health care clinics, as well as other mail order pharmacies and PBMs. Disruptive innovation by existing or new competitors could alter the competitive landscape in the future and require us to accurately identify and assess such changes and make timely and effective changes to our strategies and business model to compete effectively. Competition may also come from other sources in the future. Changes in market dynamics or the actions of competitors or manufacturers, including industry consolidation, the emergence of new competitors and strategic alliances, and decisions to exclude us from new narrow or restricted retail pharmacy networks, could materially and adversely affect our businesses, results of operations, cash flows and prospects.

We also could be adversely affected if we fail to identify or effectively respond to changes in market dynamics. For example, specialty pharmacy represents a significant and growing proportion of prescription drug spending in the United States, a significant portion of which is dispensed outside of traditional retail pharmacies. Because our specialty pharmacy operations focus on complex and high-cost medications that serve a relatively limited universe of patients, the future growth of this business depends to a significant extent upon expanding our ability to access key drugs and successfully penetrate key treatment categories.

The competitive success of our LTC pharmacy operations is dependent upon our ability to compete in each geographic region where we have operations. In the geographic regions we serve, we compete with PharMerica, our largest LTC pharmacy competitor, as well as with numerous local and regional institutional pharmacies, pharmacies owned by long-term care facilities and local retail pharmacies. Our LTC pharmacy customers consist of skilled nursing facilities, assisted living facilities, independent living communities, hospitals, correctional facilities, and other health care service providers. One of our growth opportunities is to increase our penetration rate in the assisted living segment, where residents can choose which pharmacy will provide them with prescription drugs. The ability of a resident of an assisted living facility to select the pharmacy that supplies him or her with prescription drugs could adversely affect our business, financial condition and results of operations because there can be no assurance that such resident will select us.

The competitive success of our pharmacy services business is impacted by its ability to establish and maintain contractual relationships with network pharmacies in an environment where some PBM clients are considering adopting narrow or restricted retail pharmacy networks. Competitors in the PBM industry (e.g., the Express Scripts business of Cigna Corporation,

OptumRx, Prime Therapeutics, MedImpact and Humana), include large, national PBM companies, PBMs owned by large national health plans and smaller standalone PBMs. Competition also may come from other sources in the future. In addition, changes in the overall composition of our pharmacy networks, or reduced pharmacy access under our networks, could adversely affect our claims volume and/or our competitiveness generally.

Customer contracts in our Health Care Benefits segment are generally for a period of one year, and our customers have considerable flexibility in moving between us and our competitors. One of the key factors on which we compete for customers, especially in uncertain economic environments, is overall cost. We are therefore under pressure to contain premium price increases despite being faced with increasing health care and other benefit costs and increasing operating costs. If we are unable to increase our prices to reflect increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose members to competitors with more favorable pricing, adversely affecting our revenues and results of operations. In response to rising prices, our customers may elect to self-insure or to reduce benefits in order to limit increases in their benefit costs. Alternatively, our customers may purchase different types of products from us that are less profitable. Such elections may result in reduced membership in our more profitable Insured products and/or lower premiums for our Insured products, which may adversely affect our revenues and results of operations, although such elections also may reduce our health care and other benefit costs. In addition, our Medicare, Medicaid and CHIP products are subject to termination without cause, periodic re-bid, rate adjustment and program redesign, as customers seek to contain their benefit costs, particularly in an uncertain economy. These actions may adversely affect our membership, revenues and results of operations

Competitors in each of our businesses may offer services and pricing terms that we may not be willing or able to offer. For example, strong competition in the PBM marketplace has generated greater client demand for lower pricing, increased revenue sharing and enhanced product and service offerings. Unless we can demonstrate enhanced value to our clients through innovative product and service offerings, particularly in a rapidly changing health care industry, we may be unable to remain competitive.

***We may lose clients and/or fail to win new business. If we fail to compete effectively in the geographies and product areas in which we operate, including maintaining or increasing membership in our Health Care Benefits segment, our results of operations, financial condition and cash flows could be materially and adversely affected.***

Our PBM business generates revenues primarily by contracting with clients to provide prescription drugs and related health care services to plan members. PBM client contracts often have terms of approximately three years in duration, so approximately one third of a PBM's client base typically is subject to renewal each year. In some cases, however, PBM clients may negotiate a shorter or longer contract term or may require early or periodic renegotiation of pricing prior to expiration of a contract. Our clients are generally well informed and organized, can move between our competitors and often seek competing bids prior to expiration of their contracts. In addition, the reputational impact of a service-related incident could adversely affect our businesses. These factors, together with the impact of competitive pressures, could make it difficult for us to attract new clients, retain existing clients and cross-sell additional products and/or services. Further, the PBM industry has been affected by consolidation activity that may continue in the future. If one or more of our PBM clients is acquired by an entity that is not also our client, we may be unable to retain all or a portion of the acquired client's business. These circumstances, either individually or in the aggregate, could result in an adverse effect on our businesses and financial results. Therefore, we continually face challenges in competing for new PBM business and retaining or renewing our existing PBM business. With respect to our LTC pharmacy business, reimbursement from skilled nursing facilities for prescriptions we dispense is determined pursuant to our agreements with those skilled nursing facilities. The termination of these agreements generally terminates our ability to provide services to any of the residents of that facility, resulting in the loss of revenue from any source for those residents. There can be no assurance that we will be able to win new business or secure renewal business on terms as favorable to us as the present terms.

Additionally, with respect to our retail and LTC pharmacy businesses, reimbursement under Medicare Part D, as well as reimbursement from certain private third-party payors, is determined pursuant to agreements that we negotiate with those payors or their PBM representatives. The loss of those agreements, or a material change in the terms of those agreements, could adversely affect our results of operations and cash flows. In addition, restricted networks that exclude our retail or specialty pharmacies adversely affect those businesses.

The health care and related benefits industry is highly competitive, primarily due to a large number of for-profit and not-for-profit competitors, our competitors' marketing and pricing, and a proliferation of competing products, including new products that are continually being introduced into the marketplace. Our Health Care Benefits segment faces significant competition in all of the geographies and product areas in which it operates. New entrants into the marketplace, as well as consolidation within the industry, have contributed to and are expected to intensify the competitive environment. In addition, the rapid pace of change as the industry evolves towards a consumer-focused retail marketplace, including Insurance Exchanges, and the

increased use of technology to interact with members, providers and customers, increase the risks we currently face from new entrants and disruptive actions by existing competitors compared to prior periods.

Our Health Care Benefits segment competes on the basis of many factors, including perceived overall quality, quality of service, comprehensiveness of coverage, cost (including premium, provider discounts and member out-of-pocket costs), product design, financial stability and ratings, breadth and quality of provider networks, providers available in such networks, and quality of member support and care management programs. Our Health Care Benefits segment's competitors include, among others, UnitedHealth Group Incorporated, Anthem, Inc., Humana Inc., Cigna Corporation, WellCare Health Plans, Inc., Centene Corporation, Molina Healthcare, Inc., Kaiser Permanente, health system owned health plans and new entrants into the marketplace, and numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association. The Health Care Benefits segment's largest competitor in its Medicare products is Original Medicare. Additional competitors in this segment's businesses include other types of medical and dental provider organizations, various specialty service providers (including PBM services providers), health care consultants, financial services companies, integrated health care delivery organizations (networks of providers who also coordinate administrative services for and assume insurance risk of their members), TPAs, HIT companies and, for certain plans, programs sponsored by the federal or state governments. Emerging competitors include start up health care benefit plans, provider-owned health plans, new joint ventures (including for-profit and not-for-profit joint ventures among firms from multiple industries), technology firms, financial services firms that are distributing competing products on their proprietary Private Exchanges, consulting firms that are distributing competing products on their proprietary Private Exchanges, as well as non-traditional distributors such as retail companies. In particular geographies, competitors may have greater capabilities, resources or membership; a more established reputation; superior supplier or health care professional pricing and contract terms; better business relationships; or other factors that give such competitors a competitive advantage. The Health Care Benefits segment competes for sales on Insurance Exchanges and is developing and expanding its Consumer Health Products and Services product and service offerings, where we face additional risks from existing and new competitors (including our vendors) who have lower cost structures, greater experience marketing to consumers and/or who target the higher margin portions of our business. Among the Health Care Benefits segment's international and HIT competitors, many have longer operating histories, better brand recognition and greater market presence in many of the areas in which the segment is seeking to expand and more experience at rapidly innovating products.

There can be no assurance that the Aetna Acquisition will not adversely affect any of our segments' respective abilities to attract new clients or retain existing clients or our ability to cross-sell additional products and/or services within any segment or between segments. If we do not compete effectively in the geographies and product areas in which we operate, our businesses, results of operations, financial condition and cash flows could be materially and adversely affected.

***We are exposed to risks relating to the solvency of our customers and of other insurers.***

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

We are subject to assessments under guaranty fund laws for obligations of insolvent insurance companies (such as the discounted estimated liability expense of \$231 million pretax for our estimated share of future assessments for Penn Treaty Network America Insurance Company and one of its subsidiaries that Aetna recorded in the first quarter of 2017), HMOs, ACA co-ops and other payors to policyholders and claimants.

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

We dispense significant volumes of brand-name and generic drugs from our retail, LTC, specialty and mail order pharmacies and through our PBM's network of retail pharmacies. When increased safety risk profiles or manufacturing or other supply issues of specific drugs or classes of drugs occur, or drugs become subject to greater restrictions as controlled substances, physicians may cease writing prescriptions for these drugs or the utilization of these drugs may be otherwise reduced.

Additionally, adverse publicity regarding drugs with higher safety risk profiles may result in reduced consumer demand for such drugs. On occasion, products are withdrawn by their manufacturers or transition to over-the-counter products, which can

result in lower prescription utilization. In addition, future FDA rulings could restrict the supply or increase the cost of products sold to our customers. Our results of operations and cash flows may decline as a result of such regulatory rulings or market changes.

Further, we acquire a substantial amount of our mail and specialty pharmacies' prescription drug supply from a limited number of suppliers. Our agreements with these suppliers are often short-term and easily cancelable by either party without cause. In addition, these agreements may limit our ability to provide services for competing drugs during the term of the agreement and may allow the supplier to distribute through channels other than us. Certain of these agreements also allow pricing and other terms to be adjusted periodically for changing market conditions or required service levels. A termination or modification to any of these relationships could have a material adverse effect on our businesses, financial condition and results of operations. Moreover, many products distributed by our specialty pharmacy business are manufactured with ingredients that are susceptible to supply shortages. In some cases, we depend upon a single source of supply. Any such supply shortages or loss of any such single source of supply could adversely affect our results of operations and cash flows.

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

A disruption in our business operations could occur as a result of contamination of drugs, a failure to maintain necessary shipment and storage conditions, errors in mail order processing, the unavailability of prescription drugs provided by suppliers, labor disruptions or other unanticipated disruptions at our mail order dispensing pharmacy facilities, specialty pharmacy facilities, call centers, data centers or corporate facilities, among other factors. Such disruption could reduce our ability to process and dispense prescriptions and provide products and services to our customers.

If any products we distribute are in limited supply for significant periods of time, our financial condition and results of operations could be materially and adversely affected.

***We face risks related to the frequency and rate of the introduction and pricing of generic drugs and brand name prescription drug products.***

The profitability of our Retail/LTC and Pharmacy Services segments is dependent upon the utilization of prescription drug products. Utilization trends are affected by, among other factors, the introduction of new and successful prescription drugs as well as lower-priced generic alternatives to existing brand name products because we generally earn higher gross margins on the sale of generic alternatives than on brand name equivalents. In addition, inflation in the price of brand name drugs can affect utilization, particularly given the increase in high deductible health plans. Accordingly, our businesses and results of operations could be adversely affected by a slowdown or delay in the number or magnitude of new and successful prescription drugs and/or generic alternatives, as well as inflation in the price of brand name drugs. For example, we project that the operating income of our Pharmacy Services and Retail/LTC segments may be reduced in 2019 compared to 2018 due in part to fewer new multi-source generic drugs being introduced and lower brand name drug price inflation in 2019 than 2018.

***Possible changes in industry pricing benchmarks and drug pricing generally can adversely affect our PBM business.***

It is possible that the pharmaceutical industry or regulators may evaluate and/or develop an alternative pricing reference to replace AWP or Wholesale Acquisition Cost ("WAC"), which are the pricing references used for many of our PBM and LTC client contracts, drug purchase agreements, retail network contracts, specialty payor agreements and other contracts with third party payors in connection with the reimbursement of drug payments. In addition, many state Medicaid fee-for-service programs ("FFS Medicaid") have established pharmacy network payments on the basis of Actual Acquisition Cost ("AAC"). The use of an AAC basis in FFS Medicaid could have an impact on reimbursement practices in other commercial and government products. Future changes to the use of AWP, WAC or to other published pricing benchmarks used to establish drug pricing, including changes in the basis for calculating reimbursement by federal and state health programs and/or other payors, could impact the reimbursement we receive from Medicare and Medicaid programs, the reimbursement we receive from our PBM clients and other payors and/or our ability to negotiate rebates and/or discounts with drug manufacturers, wholesalers, PBMs and retail pharmacies. A failure or inability to fully offset any increased prices or costs or to modify our operations to mitigate the impact of such increases could have a material adverse effect on our results of operations. Additionally, any future changes in drug prices could be significantly different than our projections. The effect of these possible changes on our businesses cannot be predicted at this time.

***Product liability, product recall or personal injury issues could damage our reputation.***

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

***We face challenges in growing our Medicare Advantage and Medicare Part D membership.***

We are seeking to substantially grow our Medicare Advantage and Medicare Part D membership, revenue and results of operations in 2019 and over the next several years, including by significantly expanding our Medicare Advantage service area. The organic expansion of our Medicare Advantage service area is subject to the ability of CMS to process our requests for service area expansions and our ability to build cost competitive provider networks in the expanded service areas that meet applicable network adequacy requirements. CMS' decisions on our requests for service area expansions also may be affected adversely by compliance issues that arise each year in our Medicare operations. If we are not successful in expanding our Medicare Advantage service area, we may not be able to achieve our Medicare Advantage growth goals.

***We face challenges in growing our Medicaid membership, and expanding our Medicaid membership exposes us to additional risks.***

We are seeking to substantially grow our Medicaid, dual eligible and dual eligible special needs plan membership over the next several years. In many instances, to acquire and retain our government customers' business, we must bid against our competitors in a highly competitive environment. Winning bids often are challenged successfully by unsuccessful bidders. Our ability to maintain and grow membership, revenues and results of operations in our Medicaid products is dependent on our remaining competitive on price, performance and preparing successful bids. In cases where a successful bid is challenged, we incur defense costs and may incur unreimbursed implementation and other costs to meet contractual deadlines even if we ultimately lose the challenge.

If we are successful in expanding our Medicaid membership, we may increase our exposure to states that face budgetary pressures, hospitals and other providers that face revenue challenges associated with uncompensated care and pressures on our operating margins driven by the projected rapid growth in the size of and cost of care for the Medicaid eligible population.

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

Our Insured Health Care Benefits products that involve greater potential risk generally tend to be more profitable than our ASC products. Historically, smaller employer groups have been more likely to purchase Insured Health Care Benefits products because such purchasers are generally unable or unwilling to bear greater liability for health care expenditures, although recently even relatively small employers have moved to ASC products. We also serve government-sponsored programs, including Medicare and Medicaid, that are subject to competitive bids and regulatory requirements and have lower profit margins than the Insured Commercial products in our Health Care Benefits segment. Although our Health Care Benefits membership is projected to continue to shift towards Government products in 2019, the profitability of each of those products differs and may be less than the profitability of an Insured Commercial product. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on our results of operations.

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

Premiums for our Insured Health Care Benefits products, which comprised 87% of our Health Care Benefits revenues for 2018, are priced in advance based on our forecasts of health care and other benefit costs during a fixed premium period, which is generally one year. These forecasts are typically developed several months before the fixed premium period begins, are influenced by historical data (and recent historical data in particular), are dependent on our ability to anticipate and detect medical cost trends and changes in our members' behavior and healthcare utilization patterns and require a significant degree of

judgment. For example, our revenue on Medicare policies is based on bids submitted in June of the year before the contract year. Cost increases in excess of our projections cannot be recovered in the fixed premium period through higher premiums. As a result, our profits are particularly sensitive to the accuracy of our forecasts and our ability to anticipate and detect medical cost trends. Even relatively small differences between predicted and actual health care and other benefit costs as a percentage of premium revenues can result in significant adverse changes in our results of operations.

Our health care and other benefit costs can be affected by external events that we cannot forecast or anticipate and over which we have little or no control, such as emerging changes in the economy and/or public policy, additional government mandated benefits or other regulatory changes, changes in our members' behavior and healthcare utilization patterns, changes in health care practices, new technologies, increases in the cost of prescription drugs, influenza related health care costs (which may be substantial and were higher than Aetna projected in 2017-2018), direct-to-consumer marketing by drug manufacturers, clusters of high cost cases, epidemics, pandemics, terrorist attacks or other man-made disasters, natural disasters or other events that materially increase utilization of medical and/or other covered services, including prescription drugs, as well as changes in provider billing practices. Our health care and other benefit costs also can be affected by changes in our business mix, product designs, contracts with providers, medical management, underwriting, rating and/or claims processing methods and processes, and our medical management initiatives may not deliver the reduction in utilization and/or medical cost trend that we project.

It is particularly difficult to accurately anticipate, detect, price, forecast, manage and reserve for medical cost trends and utilization of medical and/or other covered services during and following periods when such utilization and/or trends are below recent historical levels, during periods of changing economic conditions and employment levels and for products with substantial membership growth and/or turnover. For example, as of December 31, 2018, we held a premium deficiency reserve of \$16 million for the 2019 coverage year related to our Medicaid products. We expect utilization to increase in 2019 when compared to 2018.

If health care and other benefit costs are higher than the levels reflected in our pricing or if we are not able to obtain appropriate pricing on new or renewal business, our prices will not reflect the risk we assume, and our results of operations will be adversely affected. If health care and other benefit costs are lower than we predict, our prices may be higher than those of our competitors, which may cause us to lose Health Care Benefits membership.

***A number of factors, many of which are beyond our control, contribute to rising health care and other benefit costs. If we are unable to satisfactorily manage our health care and other benefit costs, our Health Care Benefits segment's results of operations and competitiveness will be adversely affected.***

A number of factors contribute to rising health care and other benefit costs, including previously uninsured members entering the health care system, changes in members' behavior and healthcare utilization patterns, turnover in our membership, additional government mandated benefits or other regulatory changes, changes in the health status of our members, the aging of the population and other changing demographic characteristics, advances in medical technology, increases in the number and cost of prescription drugs (including specialty pharmacy drugs), direct-to-consumer marketing by drug manufacturers, the increasing influence of social media on our members' utilization and other behavior, changes in health care practices and inflation. In addition, government-imposed limitations on Medicare and Medicaid reimbursements to health plans and providers have caused the private sector to bear a greater share of increasing health care and other benefits costs over time, and future amendments or repeal or replacement of the ACA that increase the uninsured population may exacerbate this problem. Other factors that affect our health care and other benefit costs include changes as a result of the ACA, changes to the ACA and other changes in the regulatory environment, the evolution toward a consumer driven business model, changes in health care practices, general economic conditions (such as inflation and employment levels), new technologies, influenza related health care costs (which may be substantial and were higher than Aetna projected in 2017-2018), clusters of high-cost cases, epidemics or pandemics, health care provider and member fraud, and numerous other factors that are or may be beyond our control.

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

***The reserves we hold for expected claims in our Insured Health Care Benefits products are based on estimates that involve an extensive degree of judgment and are inherently variable. Any reserve, including a premium deficiency reserve, may be***

***insufficient. If actual claims exceed our estimates, our results of operations could be materially adversely affected, and our ability to take timely corrective actions to limit future costs may be limited.***

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

Our estimates of health care costs payable are based on a number of factors, including those derived from historical claim experience, but this estimation process also makes use of extensive judgment. Considerable variability is inherent in such estimates, and the accuracy of the estimates is highly sensitive to changes in medical claims submission and processing patterns and/or procedures, turnover and other changes in membership, changes in product mix, changes in the utilization of medical and/or other covered services, including prescription drugs, changes in medical cost trends, changes in our medical management practices and the introduction of new benefits and products. We estimate health care costs payable periodically, and any resulting adjustments, including premium deficiency reserves, are reflected in current-period results of operations within benefit costs. For example, as of December 31, 2018, we held a premium deficiency reserve of \$16 million for the 2019 coverage year related to our Medicaid products. A worsening (or improvement) of health care cost trend rates or changes in claim payment patterns from those that we assumed in estimating health care costs payable as of December 31, 2018 would cause these estimates to change in the near term, and such a change could be material.

Furthermore, if we are not able to accurately and promptly anticipate and detect medical cost trends or accurately estimate the cost of incurred but not yet reported claims or reported claims that have not been paid, our ability to take timely corrective actions to limit future costs and reflect our current benefit cost experience in our pricing process may be limited, which would further exacerbate the extent of any adverse impact on our results of operations. These risks are particularly acute during and following periods when utilization of medical and/or other covered services and/or medical cost trends are below recent historical levels and in products where there is significant turnover in our membership each year, and such risks are further magnified by the ACA and other legislation and regulations that limit our ability to price for our projected and/or experienced increases in utilization and/or medical cost trends.

***Extreme events, or the threat of extreme events, could materially increase our health care (including behavioral health) costs. We cannot predict whether or when any such events will occur.***

Nuclear, biological or other attacks, whether as a result of war or terrorism, other man-made disasters, natural disasters, epidemics, pandemics and other extreme events can affect the United States economy in general, our industries and us specifically. In particular, such extreme events or the threat of such extreme events could result in significant health care (including behavioral health) costs, which would also be affected by the government's actions and the responsiveness of public health agencies and other insurers. In addition, our employees and those of our vendors are concentrated in certain large, metropolitan areas which may be particularly exposed to these events. Such events could adversely affect our businesses, cash flows and results of operations, and, in the event of extreme circumstances, our financial condition or viability, particularly if our responses to such events are less adequate than those of our competitors.

## **Changes in Public Policy and Other Legal and Regulatory Risks**

***Legislative and regulatory changes could create significant challenges to our Medicare Advantage and Medicare Part D revenues and results of operations, and proposed changes to these programs could create significant additional challenges. Entitlement program reform, if it occurs, could have a material adverse effect on our businesses, operations and/or results of operations.***

Medicare Advantage payment rates to health plans have been cut over the last several years, with additional reductions to be phased in through 2019. CMS issued the Final Notice in April 2018. Overall, we project the benchmark rates in the Final Notice will increase funding for our Medicare Advantage business, excluding the impact of coding trend, by approximately 2.5 percent in 2019 compared to 2018. This 2019 rate increase only slightly offsets the challenge we face from the impact of the increasing cost of medical care (including prescription medications), the HIF and CMS local and national coverage decisions that require us to pay for services and supplies that are not factored into our bids and creates continued pressure on the Medicare Advantage program and our Medicare Advantage results of operations. We cannot predict future Medicare funding levels, the impact of future federal budget actions or ensure that such changes or actions will not have an adverse effect on our Medicare results of operations.

In addition, the “star ratings” from CMS for our Medicare Advantage plans will continue to have a significant effect on our plans’ results of operations. Since 2015, only Medicare Advantage plans with a star rating of four or higher (out of five) are eligible for a quality bonus in their basic premium rates. CMS continues to change its rating system to make achieving and maintaining a four or higher star rating more difficult. Our star ratings and past performance scores are adversely affected by the compliance issues that arise each year in our Medicare operations. If our star ratings fall below 4 for a significant portion of our Medicare Advantage membership or do not match the performance of our competitors or the star rating quality bonuses are reduced or eliminated, our revenues and results of operations may be significantly adversely affected.

Payments we receive from CMS for our Medicare Advantage and Part D businesses also are subject to risk adjustment based on the health status of the individuals we enroll. Elements of that risk adjustment mechanism continue to be challenged by the DOJ, the OIG and CMS itself. Substantial changes in the risk adjustment mechanism, including changes that result from enforcement or audit actions, could materially affect the fairness of our Medicare reimbursement, require us to raise prices or reduce the benefits we offer to Medicare beneficiaries, and potentially limit our (and the industry’s) participation in the Medicare program.

Medicare Part D has resulted in increased utilization of prescription medications and puts pressure on our pharmacy gross margin rates due to regulatory and competitive pressures. Further, as a result of the ACA and changes to the retiree drug subsidy rules, clients of our PBM could decide to discontinue providing prescription drug benefits to their Medicare-eligible members. To the extent this phenomenon occurs, the adverse effects of increasing customer migration into Medicare Part D may outweigh the benefits we realize from growth of our Medicare Part D business. In addition, if the cost and complexity of Medicare Part D exceed management’s expectations or prevent effective program implementation or administration; if changes to the regulations regarding how drug costs are reported for Medicare Part D are implemented in a manner that adversely affects the profitability of our Medicare Part D business; if changes to the applicable regulations impact our ability to retain fees from third parties including network pharmacies; if the government alters Medicare Part D program requirements or reduces funding because of the higher-than-anticipated cost to taxpayers of Medicare Part D or for other reasons; if the government mandates the use of point-of-sale manufacturer’s rebates or up front drug pricing discounts, makes drug manufacturer’s rebates illegal, or makes changes to how pharmacy pay-for-performance is calculated; or if reinsurance thresholds are reduced below their current levels, our Medicare Part D results of operations and our ability to expand our Medicare Part D business could be adversely affected.

More generally, our Medicare results of operations and our ability to expand our Medicare membership and revenues also could be adversely affected if we fail to design and maintain programs that are attractive to Medicare Advantage or Part D participants; if CMS imposes restrictions on our Medicare business as a result of audits or other regulatory actions; if we fail to successfully implement corrective actions or other remedial measures sufficient to prevent or remove any applicable restrictions that may be imposed by CMS; or if we are not successful in retaining enrollees, or winning contract renewals or new contracts under Medicare’s competitive bidding process.

Federal funding for expanded Medicaid coverage began to decrease in 2017. This reduction is causing states to re-evaluate funding for their Medicaid expansions. That re-evaluation may adversely affect Medicaid payment rates, our Medicaid membership in those states, our revenues, our MBRs and our results of operations.

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

Premium rates for our Insured Health Care Benefits products generally must be filed with state insurance regulators and are subject to their approval, which creates risk for us in the current political and regulatory environment. The ACA generally requires a review by HHS in conjunction with state regulators of premium rate increases that exceed a federally specified threshold (or lower state-specific thresholds set by states determined by HHS to have adequate processes). Rate reviews can magnify the adverse impact on our operating margins and results of operations of increases in health care and other benefit costs, increased utilization of covered services, and ACA assessments, fees and taxes, by restricting our ability to reflect these increases and/or these assessments, fees and taxes in our pricing. The risk of increases in utilization of medical and/or other covered services and/or in health care and other benefit costs is particularly acute during and following periods when utilization has been below recent historical levels, during periods of changing economic conditions and/or employment levels and in products where there is significant turnover in our membership each year. Further, our ability to reflect ACA assessments, fees and taxes in our Medicare rates is limited. Similarly, our ability to reflect them in our Medicaid and/or CHIP premium rates is limited due, among other things, to the budgetary pressures currently facing many state governments. This could magnify the adverse impact on our operating margins and results of operations of increases in utilization of medical and other covered services, health care and other benefit costs and/or medical cost trends that exceed our projections.

Since 2013, HHS has issued determinations to health plans that their rate increases were “unreasonable,” and we continue to experience challenges to appropriate premium rate increases in certain states. Regulators or legislatures in a number of states have implemented or are considering limits on premium rate increases, either by enforcing existing legal requirements more stringently or proposing different regulatory standards. Regulators or legislatures in a number of states also have conducted hearings on proposed premium rate increases, which can result, in some instances have resulted, in substantial delays in implementing proposed rate increases even if they ultimately are approved. Our plans can be excluded from participating in small group Public Exchanges if they are deemed to have a history of “unreasonable” rate increases. We requested significant increases in our premium rates in our small group Commercial Health Care Benefits products for 2019 and expect to continue to request significant increases in those rates for 2020 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and significant assessments, fees and taxes imposed by the federal and state governments, including the ACA. Our rates also must be adequate to reflect the risk that our products will be selected by people with a higher risk profile or utilization rate than the pool of participants we anticipated when we established the pricing for the applicable products (also known as “adverse selection”) in our products, particularly in small group products, which we expect to continue and potentially worsen in 2019 following the expiration of the ACA’s risk corridor and reinsurance programs at the end of 2016. These significant rate increases heighten the risks of adverse public and regulatory reaction and adverse selection and the likelihood that our requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

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

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

The ACA requires us to pay minimum MLR rebates each year with respect to prior years. The ACA’s minimum MLR rebate requirements limit the level of margin we can earn in our Commercial Insured and Medicare Insured businesses. CMS minimum MLR rebate regulations limit the level of margin we can earn in our Medicaid Insured business. Certain portions of our Health Care Benefits Medicaid and FEHB program business also are subject to minimum MLR rebate requirements in addition to but separate from those imposed by the ACA. Minimum MLR rebate requirements leave us exposed to medical costs that are higher than those reflected in our pricing. The process supporting the management and determination of the amount of MLR rebates payable is complex and requires judgment, and the minimum MLR reporting requirements are detailed. Federal and state auditors are challenging our Commercial Health Care Benefits business’ compliance with the ACA’s minimum MLR requirements as well as our FEHB plans’ compliance with the OPM’s FEHB program-specific minimum MLR requirements. Our Medicare and Medicaid contracts also are subject to minimum MLR audits. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS. Additional challenges to our methodology and/or reports relating to minimum MLR and related rebates by federal and state regulators and private litigants are reasonably possible. The outcome of these audits and additional challenges could adversely affect our results of operations.

***Our business activities are highly regulated. Our Pharmacy Services, Medicare Advantage, Medicare Part D, Medicaid, dual eligible, dual eligible special needs plan, small group and certain other products are subject to particularly extensive and complex regulations. If we fail to comply with applicable laws and regulations, we could be subject to significant adverse regulatory actions or suffer brand and reputational harm which may have a material adverse effect on our businesses. Compliance with existing and future laws, regulations and/or judicial decisions may reduce our profitability and limit our growth.***

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

Our Pharmacy Services products are subject to:

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

Our Health Care Benefits products are highly regulated, particularly those that serve Medicare, Medicaid, dual eligible, dual eligible special needs and small group Commercial customers and members. The laws and regulations governing participation in Medicare Advantage, Medicare Part D, Medicaid, dual eligible and dual eligible special needs plan programs are complex, are subject to interpretation and can expose us to penalties for non-compliance, including penalties under the False Claims Act and state false claims acts. In addition, the ACA may have expanded the jurisdiction of, and our exposure to, the False Claims Act to products that are sold on Public Exchanges or otherwise subject to the ACA. The scope of the practices and activities that are prohibited by federal and state false claims acts is the subject of pending litigation. Claims under federal and state false claims acts can be brought by the government or by private individuals on behalf of the government through a *qui tam* or “whistleblower” suit, and we are a defendant in a number of such proceedings. If we are convicted of fraud or other criminal conduct in the performance of a health program or if there is an adverse decision against us under the False Claims Act, we may be temporarily or permanently suspended from participating in government health care programs, including Medicare Advantage, Medicare Part D, Medicaid, dual eligible and dual eligible special needs plan programs, and we also may be required to pay significant fines and/or other monetary penalties.

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

Our businesses, profitability and growth also may be adversely affected by (i) judicial and regulatory decisions that change and/or expand the interpretations of existing statutes and regulations, impose medical or bad faith liability, increase our responsibilities under ERISA or the remedies available under ERISA, or reduce the scope of ERISA pre-emption of state law claims or (ii) other legislation and regulations.

***If our compliance or other systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions or litigation which could adversely affect our businesses, results of operations, cash flows and/or financial condition.***

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

***Our litigation and regulatory risk profile are changing as a result of the Aetna Acquisition and as we offer new products and services and expand in business areas beyond our historical core businesses of Retail/LTC and Pharmacy Services.***

Historically, we focused primarily on providing Retail/LTC and Pharmacy Services products and services. As a result of the Aetna Acquisition, we have significantly expanded our presence in Health Care Benefits products and services (including

products and services offered in multiple countries outside of the United States), which present a different litigation and regulatory risk profile than the products and services that we historically have offered.

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

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

Pharmacy services, retail pharmacy, LTC pharmacy and health care benefits are highly regulated and litigious industries. We are currently subject to various litigation matters, investigations, regulatory audits, inspections, government inquiries, and regulatory and other legal proceedings. Litigation, and particularly securities, collective or class action and *qui tam* litigation, is often expensive and disruptive. Certain of the lawsuits against us are or are purported to be class actions or *qui tam* actions. Litigation related to our provision of professional services in our pharmacies, specialty pharmacies, medical clinics and LTC facilities also has increased as we expand our services along the continuum of health care.

The majority of these proceedings relate to the conduct of our Retail/LTC, Pharmacy Services and Health Care Benefits operations and allege various violations of law. In addition, we operate in jurisdictions outside the United States, where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and are therefore more likely to be subject to dispute by customers, members, governmental authorities and others. We are incurring expenses to resolve these proceedings. The outcome of litigation and other adverse legal proceedings is always uncertain, and outcomes that are not justifiable by the evidence or existing law or regulation can and do occur.

Litigation has been and may be brought against us by private individuals on behalf of the government through a *qui tam* or “whistleblower” suit. Under the provisions of the federal and various state false claims acts, private citizens may bring lawsuits alleging that a violation of the federal anti-kickback statute or similar laws has resulted in the submission of “false” claims to federal and/or state health care programs, including Medicare and Medicaid, and we are a defendant in a number of such proceedings. When a private individual brings a whistleblower suit, the defendant often will not be made aware of the suit for many months or even years, until the government commences its own investigation or determines whether it will intervene. Whistleblower suits have resulted in significant settlements between governmental agencies and health care companies. The significant incentives and protections provided under the Financial Reform Act increase the risk of whistleblower suits.

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

We cannot predict the outcome of any of these matters, and the costs incurred may be substantial regardless of outcome. Litigation and other adverse legal proceedings could materially adversely affect our businesses or results of operations because of brand and reputational harm to us caused by such proceedings, the costs of defending such proceedings, the costs of settlement or judgments against us, or the changes in our operations that could result from such proceedings. See Item 3 of this Annual Report on Form 10-K for additional information.

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

As one of the largest national retail and LTC pharmacy, pharmacy services and health care benefits providers, we frequently are subject to regular and special governmental market conduct and other audits, investigations and reviews by, and we receive subpoenas and other requests for information from, various federal and state agencies, regulatory authorities, attorneys general, committees, subcommittees and members of the United States Congress and other state, federal and international governmental authorities. For example, we have received CIDs from, and provided documents and information to, the Civil Division of the

DOJ in cooperation with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. Several such audits, investigations and reviews currently are pending, some of which may be resolved in 2019, and the results of which may be adverse to us.

Federal and state governments have made investigating and prosecuting health care and other insurance fraud, waste and abuse a priority. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical and/or other covered services, improper marketing and violations of patient privacy rights. The regulations and contractual requirements applicable to us and other industry participants are complex and subject to change, making it necessary for us to invest significant resources in complying with our regulatory and contractual requirements. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources. In addition, our medical costs and the medical expenses of our Health Care Benefits ASC customers may be adversely affected if we do not prevent or detect fraudulent activity by providers and/or members.

Regular and special governmental audits, investigations and reviews by federal, state and international regulators could result in changes to our business practices, and also could result in significant or material premium refunds, fines, penalties, civil liabilities, criminal liabilities or other sanctions, including suspension or exclusion from participation in government programs and suspension or loss of licensure. Any of these audits, investigations or reviews could have a material adverse effect on our financial condition, results of operations or businesses or result in significant liabilities and negative publicity for our company. For example, since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various years for RADV audit. In addition, federal and state auditors are challenging our Commercial Health Care Benefits business' compliance with the ACA's minimum MLR requirements as well as our FEHB plans' compliance with OPM's FEHB program-specific minimum MLR requirements. Our Medicare and Medicaid contracts also are subject to minimum MLR audits. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS.

***We are subject to retroactive adjustments to and/or withholding of certain premiums and fees, including as a result of CMS RADV audits. We generally rely on health care providers to appropriately code claim submissions and document their medical records. If these records do not appropriately support our risk adjusted premiums, we may be required to refund premium payments to CMS and/or pay fines and penalties under the False Claims Act.***

Premiums and/or fees for Medicare members, certain federal government employee groups and Medicaid beneficiaries are subject to retroactive adjustments and/or withholding by the federal and applicable state governments. Our business that is subject to the ACA, including amounts payable to us or payable by us under the ACA's premium stabilization programs and our risk adjustment and reinsurance data, also is subject to audit by governmental authorities. CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of the services we provide to our Medicare members.

CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions to us and document their medical records, including the diagnosis data submitted to us with claims. CMS pays increased premiums to Medicare Advantage plans and PDPs for members who have certain medical conditions identified with specific diagnosis codes.

Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted RADV audits of a subset of Medicare Advantage plans for various contract years, including certain of our plans for various contract years, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require us to refund premium payments if our risk adjusted premiums are not properly supported by medical record data. The OIG also is auditing our risk adjustment data and that of other companies, and we expect CMS and the OIG to continue auditing risk adjustment data. We also have received CIDs from, and provided documents and information to, the Civil Division of the DOJ in connection with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified

in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. For contract years prior to 2011, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase our exposure to premium refunds to CMS based on incomplete medical records maintained by providers. On October 26, 2018, CMS issued proposed rules related to, among other things, changes to the RADV audit methodology established by CMS in 2012. CMS projects that the changes to the RADV audit methodology would increase its recoveries from Medicare Advantage plans as a result of RADV audits. CMS has requested comments on the proposed rules, including whether the proposed RADV rule change should apply retroactively to audits of Medicare Advantage plans for contract year 2011 and forward. We are evaluating the potential adverse effect, which could be material, on our results of operations, financial condition and cash flows if the proposed RADV rule change were adopted as proposed. CMS also has announced its intent to use third party auditors to attain its ultimate goal of subjecting all Medicare Advantage contracts to either a comprehensive or a targeted RADV audit for each contract year. We are currently unable to predict which of our Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect of any such refunds or adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would require us to change our method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in our bids for prior contract years, the current contract year or future contract years.

If we fail to report and correct errors discovered through our own auditing procedures or during a CMS audit or otherwise fail to comply with the applicable laws and regulations, we could be subject to fines, civil monetary penalties or other sanctions, including fines and penalties under the False Claims Act, which could have a material adverse effect on our ability to participate in Medicare Advantage, Part D or other government programs, and on our financial condition, cash flows and results of operations.

CMS has issued a final rule implementing ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. However, CMS's statements in formalized guidance regarding "overpayments" to Medicare Advantage plans appear to be inconsistent with CMS's prior RADV audit guidance. These statements appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without reconciliation to the principles underlying the fee for service adjustment comparison contemplated by CMS's RADV audit methodology. The precise interpretation, impact and legality of the final rule are not clear and are subject to pending litigation. If Medicare Advantage plans were not paid based on payment model principles that align with the requirements of the Social Security Act or such payments were not implemented correctly, it could have a material adverse effect on our results of operations, financial condition and/or cash flows.

Certain of our Medicaid contracts require the submission of complete and correct encounter data. The accurate and timely reporting of encounter data is increasingly important to the success of our Medicaid programs because more states are using encounter data to determine compliance with performance standards and, in part, to set premium rates. We have expended and may continue to expend additional effort and incur significant additional costs to collect accurate, or to correct inaccurate or incomplete, encounter data and have been and could be exposed to premium withholding, operating sanctions and financial fines and penalties for noncompliance. We have experienced challenges in obtaining complete and accurate encounter data due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could affect the Medicaid premium rates we receive and how Medicaid membership is assigned to us, which could have a material adverse effect on our Medicaid results of operations and cash flows and/or our ability to bid for, and continue to participate in, certain Medicaid programs.

Any premium or fee refunds, adjustments or withholding or civil or criminal fines or penalties, or other sanctions, including restrictions on or changes in the way we do business, loss of licensure or exclusion from participation in government programs, resulting from regulatory audits or investigations, whether as a result of RADV, Public Exchange related, recovery audit program or other audits or investigations by CMS, the OIG, HHS, the DOJ or otherwise, including audits of our minimum MLR rebates, methodology and/or reports, could be material and could adversely affect our results of operations, financial condition and cash flows.

***Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues. The U.S. federal government and our other government customers may reduce funding for health care or other programs, cancel or decline to renew contracts with us, or make changes that adversely affect the number of persons eligible for certain programs, the services provided to enrollees in such programs, our premiums and our administrative and health care and other benefit costs, any of which could have a material adverse effect on our businesses, results of operations and cash flows. In addition, an extended federal government shutdown or a delay by Congress in raising the federal government's debt ceiling could lead to a delay, reduction, suspension or cancellation of federal government spending and a***

***significant increase in interest rates that could, in turn, have a material adverse effect on our businesses, results of operations and cash flows.***

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

Our revenues from government funded programs, including our Medicare, Medicaid, dual eligible and dual eligible special needs plan businesses and our government customers in our Commercial business, are dependent on annual funding by the federal government and/or applicable state or local governments. Federal, state and local governments have the right to cancel or not to renew their contracts with us on short notice without cause or if funds are not available. Funding for these programs is dependent on many factors outside our control, including general economic conditions, continuing government efforts to contain health care costs and budgetary constraints at the federal or applicable state or local level and general political issues and priorities.

For example, CMS is transitioning the process of calculating Medicare members' risk scores from using diagnoses data from the Risk Adjustment Processing System, or RAPS, to using diagnoses data from the Encounter Data System, or EDS. The RAPS process requires Medicare Advantage plans to apply a filter logic based on CMS guidelines and only submit claims that satisfy those guidelines. For submissions through EDS, CMS requires Medicare Advantage plans to submit all encounter data, and CMS applies the risk adjustment filtering logic to determine the risk scores. For 2019, 25% of the risk score will be calculated from claims data submitted through EDS, up from 15% in 2018. For 2020, the EDS percentage will increase to 50%. The transition from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues or filtering logic differences between RAPS and EDS and could have a material adverse effect on our results of operations, financial condition and/or cash flows.

In addition, while the ACA provided substantial federal funding for the expansion of the number of people who qualify to enroll in Medicaid beginning in 2014, that funding began to decrease in 2017, and the future of that funding is uncertain. As a result, in 2019, states are preparing for the adverse impact on their budgets and programs by seeking to reduce their Medicaid expenditures and/or changing the design of their Medicaid programs. These changes could have a material adverse effect on the revenues, medical benefit ratios and results operations of our Medicaid contracts and/or our ability to grow our Medicaid membership, revenues and results of operations.

Our government customers also determine the eligibility criteria, premium levels and other aspects of Medicare, Medicaid, dual eligible and dual eligible special needs plan programs that affect the number of persons enrolled in these programs, the services provided to enrollees under these programs, the conditions for participating in these programs and our administrative and health care and other benefit costs under these programs. For example, states may require participation on their Public Exchange as a condition to participating in their Medicaid or state employee health benefit programs and/or take program design actions that shift provider costs from state employee plans to Commercial and Medicare plans. In the past, determinations of this type have at times adversely affected our results of operations from and willingness to participate in such programs, and they may do so again in the future. If a government customer reduces premium levels or increases premiums by less than the increase in our costs (such as by not allowing us to recover ACA and other applicable fees, taxes and assessments), and we cannot offset the adverse impact of these actions with supplemental premiums and/or changes in benefit plans, then our businesses and results of operations could be adversely affected. In addition, if states allow certain programs to expire, reduce the number of firms with which they contract for Managed Medicaid services or choose to opt out of Medicaid expansion, we could experience reduced Medicaid enrollment or reduced Medicaid enrollment growth, which would adversely affect our businesses, revenues and results of operations.

The federal government's "debt ceiling", or the amount of debt the federal government is permitted to borrow to meet its legal obligations (including, among other things, interest on the national debt, Medicare and Medicaid premiums and contributions to the FEHB program), is limited by statute and can only be raised by an act of Congress.

During a federal government shutdown or if Congress does not raise the debt ceiling before the federal government's current obligations approach or exceed its cash on hand and incoming receipts, federal government spending may be subject to delay, reduction, suspension or cancellation, which may be prolonged. Over 30% of our Health Care Benefits segment's revenues are derived from health care coverage programs that are funded in whole or in part by the federal government, including the Medicare, Medicaid, dual eligible and dual eligible special needs plan programs, CHIP and the FEHB program. When federal spending is delayed, suspended or curtailed, we continue to receive claims from providers providing services to beneficiaries of these programs, and we remain liable for, and are required to fund, such claims. A federal government shutdown or a failure to

timely raise the debt ceiling could have a material adverse effect on our businesses, results of operations, cash flows, brand and reputation and, in the case of a prolonged shutdown or failure to raise the debt ceiling, our financial condition.

If the United States defaults on its obligations due to a failure to timely raise the debt ceiling or otherwise, or its credit rating is downgraded by any of the credit rating agencies, interest rates could rise, financial markets could become volatile and/or the availability of credit (and short-term credit in particular) could be adversely affected, thereby increasing our borrowing costs, adversely affecting the value of our investment portfolio, and/or adversely affecting our ability to access the capital markets, which could have a material adverse effect on our results of operations, financial condition and cash flows and could adversely affect our liquidity.

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

The federal and certain state legislatures continue to consider and pass legislation that increases our costs of doing business, including increased minimum wages and requiring employers to provide paid sick leave. In addition, our employee related operating costs may be increased by union organizing activity. If we are unable to reflect these increased expenses in our pricing or otherwise modify our operations to mitigate the effects of such increases, our results of operations will be adversely affected.

### **Risks Related to Customer Perceptions of our Products and Services**

***We must develop and maintain a relevant omni-channel experience for our retail customers.***

Our business has evolved from a retail store experience to interaction with customers across numerous channels, including in-store, online, mobile and social media, among others. Omni-channel retailing is rapidly evolving and we must keep pace with changing customer expectations and new developments by our competitors. Our customers are increasingly using mobile phones, tablets, computers and other devices to comparison shop, determine product availability and complete purchases through mobile commerce applications. As a result, the portion of total consumer expenditures with all retailers occurring online and through mobile commerce applications is increasing and the pace of this increase could accelerate. We must compete by offering a consistent and convenient shopping experience for our customers regardless of the ultimate sales channel and by investing in, providing and maintaining mobile commerce applications for our customers that have the right features and are reliable and easy to use. If we are unable to make, improve or develop relevant customer-facing technology in a timely manner that keeps pace with technological developments and dynamic customer expectations, our ability to compete and our results of operations could be materially and adversely affected. In addition, if our online activities or our other customer-facing technology systems do not function as designed, we may experience a loss of customer confidence, data security breaches, lost sales, or be exposed to fraudulent purchases, any of which could materially and adversely affect our business operations, reputation and results of operations.

***We must maintain and improve our relationships with our retail and specialty pharmacy customers and increase the demand for our products and services, including proprietary brands. If we fail to develop new products, differentiate our products from those of our competitors or demonstrate the value of our products to our customers and members, our ability to retain or grow our customer base may be adversely affected.***

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

We offer our retail customers proprietary brand products that are available exclusively at our retail stores and through our online retail sites. The sale of proprietary products subjects us to unique risks including potential product liability risks, mandatory or voluntary product recalls, potential supply chain and distribution chain disruptions for raw materials and finished products, our ability to successfully protect our intellectual property rights and the rights of applicable third parties, and other risks generally encountered by entities that source, market and sell private-label products. Any failure to adequately address some or all of these risks could have an adverse effect on our retail business, results of operations and financial condition. Additionally, an increase in the sales of our proprietary brands may adversely affect our sales of products owned by our suppliers which, consequently, could adversely impact certain of our supplier relationships. Our ability to locate qualified, economically stable suppliers who satisfy our requirements, and to acquire sufficient products in a timely and effective manner,

is critical to ensuring, among other things, that customer confidence is not diminished. Any failure to develop sourcing relationships with a broad and deep supplier base could adversely affect our financial performance and erode customer loyalty.

Our specialty pharmacy business focuses on complex and high-cost medications, many of which are made available by manufacturers to a limited number of pharmacies (so-called limited distribution drugs), that serve a relatively limited universe of patients. As a result, the future growth of our specialty pharmacy business is dependent largely upon expanding our base of drugs or penetration in certain treatment categories. Any contraction of our base of patients or reduction in demand for the prescriptions we currently dispense could have an adverse effect on our specialty pharmacy business, results of operations and cash flows.

We operate in rapidly evolving industries. Our customers generally, and our larger customers in particular, are well-informed and organized and, along with our individual customers, can easily move between us and our competitors. These factors require us to differentiate our products and solutions, anticipate changes in customer and consumer preferences, anticipate and effectively compete with the products and solutions of new and existing competitors and innovate and deliver new and existing products and solutions that demonstrate value to our customers and members, particularly in response to marketplace changes from public policy. Any failure to do so may adversely affect our ability to retain or grow customers and/or profitable medical membership, which can adversely affect our results of operations.

***In order to be competitive in the increasingly consumer-oriented marketplace for our health care products and services, we will need to develop and deploy consumer-friendly products and services and make investments in consumer engagement, reduce our cost structure and compete successfully with new entrants into our businesses. If we are unsuccessful, our future growth and profitability may be adversely affected.***

Historically, employers have been the most significant customers driving purchases of our Pharmacy Services and Health Care Benefits segments. However, decisions to buy our Pharmacy Services and Health Care Benefits products and services increasingly are made or influenced by consumers, either through direct purchasing (for example, Medicare Advantage plans and PDPs) or through Insurance Exchanges that allow individual choice. Similarly, consumers increasingly seek to access health care products and services locally and through other direct channels such as mobile devices and our websites. In response to this demand, we are expanding our consumer focus. To compete effectively in the consumer-driven marketplace, we will be required to develop or acquire new capabilities, attract new talent and develop new service and distribution relationships that respond to consumer needs and preferences.

We also will have to respond to pricing and other actions taken by existing competitors as well as potentially disruptive new entrants. Regulatory and participation requirements for Insurance Exchange-based plans tend to emphasize price and make competitive differentiation of our Health Care Benefits products and services based on other attributes more difficult. Price competition from existing and potentially new disruptive competitors in the industries in which each of our segments compete also continues to increase. Accordingly, we face competitive pricing pressures from existing and new competitors (including our vendors and others who may have lower cost structures than we do), and these pressures may reduce our operating margins or limit sales of our products and services. Our competitors may bring their consumer-oriented products and services to market more quickly, have greater experience marketing to consumers and/or may be targeting the higher margin portions of our businesses. These risks may be enhanced if employers shift to defined contribution health care benefits plans and make greater utilization of Private Exchanges or encourage their employees to purchase health insurance on the Public Exchanges. We can provide no assurance that we will be able to develop or operate successful or profitable consumer-oriented products and services, or that our Health Care Benefits segment will be able to compete successfully or profitably on Public Exchanges or Private Exchanges or benefit from any opportunities presented by Public Exchanges or Private Exchanges, or that we will be able to benefit from opportunities available to any of our segments in the industries in which we operate. If we do not develop and expand competitive and profitable consumer products, are not competitive in the industries in which we operate, or are unsuccessful in reducing our cost structure, our future growth and profitability may be adversely affected.

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

***Our results of operations may be adversely affected if we are unable to contract with manufacturers, providers, suppliers and vendors on competitive terms and develop and maintain attractive networks with high quality providers.***

Our PBM business generates revenues primarily by contracting with clients to provide prescription drugs and related health care services to plan members. As a result, we are dependent on our relationships with prescription drug manufacturers and suppliers. We acquire a substantial amount of our mail order and specialty pharmacies' prescription drug supply from a limited number of suppliers. Our agreements with these suppliers often are short-term and easily cancelable by either party without cause. In addition, these agreements may limit our ability to provide services for competing drugs during the term of the

agreement and may allow the supplier to distribute through channels other than the Company. A termination or modification to any of these relationships could have a material adverse effect on our businesses, financial condition and results of operations.

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

While we believe joint ventures, ACOs and other non-traditional health care provider organizational structures present opportunities for us, the implementation of our joint ventures and other non-traditional structure strategies may not achieve the intended results, which could adversely affect our results of operations and cash flows. Among other things, joint ventures require us to maintain collaborative relationships with our counterparties, continue to gain access to provider rates that make the joint ventures economically sustainable and devote significant management time to the operation and management of the joint venture. We may not be able to achieve these objectives in one or more of our joint ventures, which could adversely affect our results of operations and cash flows.

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

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

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

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

Hospitals and other providers and health systems continue to consolidate across the health care industry. While this consolidation could increase efficiency and has the potential to improve the delivery of health care services, it also reduces competition and the number of potential contracting parties in certain geographies. These health systems also are increasingly forming and considering forming health plans to directly offer health insurance in competition with us, a process that has been accelerated by the ACA. In addition, ACOs (including commercial and Medicaid-only ACOs developed as a result of state Medicaid laws), practice management companies, consolidation among and by integrated health systems and other changes in the organizational structures that physicians, hospitals and other health care providers adopt continues to change the way these providers interact with us and the competitive landscape in which we operate. These changes may increase our medical and other covered benefits costs, may affect the way we price our products and services and estimate our medical and other covered benefits costs and may require us to change our operations, including by withdrawing from certain geographies where we do not have a significant presence across our businesses or are unable to collaborate or contract with providers on acceptable terms. Each of these changes may adversely affect our businesses and results of operations.

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

Some providers that render services to our Health Care Benefits members do not have contracts with us. In those cases, we do not have a pre-established understanding with these providers as to the amount of compensation that is due to them for services rendered to our members. In some states, the amount of compensation due to these nonparticipating providers is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover the difference between what we have paid them and the amount they charged us from our members, which may result in customer and member dissatisfaction. For example, on October 15, 2018, an arbitrator awarded certain claimant hospitals approximately \$150 million in a proceeding relating to Aetna's out-of-network benefit payment and administration practices. Such disputes may cause us to pay higher medical or other benefit costs than we projected.

## **Risks Related to Our Operations**

***Customers, particularly large sophisticated customers, expect us to implement their contracts and onboard their employees and members efficiently and effectively. Failure to do so could adversely affect our reputation, businesses, results of operations, cash flows and prospects. If we or our vendors fail to provide our customers with quality service that meets their expectations, our ability to retain and grow our membership and customer base will be adversely affected.***

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

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

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

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

We and our vendors are subject to business continuity hazards and other risks, including natural disasters, utility and other mechanical failures, acts of war or terrorism, disruption of communications, data security and preservation, disruption of supply or distribution, safety regulation and labor difficulties. The occurrence of any of these or other events to the Company or our vendors might disrupt or shut down our operations or otherwise adversely affect our operations. We may also be subject to certain liability claims in the event of an injury or loss of life, or damage to property, resulting from such events. Although we

have developed procedures for crisis management and disaster recovery and business continuity plans and maintain insurance policies that we believe are customary and adequate for our size and industry, our insurance policies include limits and, as such, our coverage may be insufficient to protect against all potential hazards and risks incident to our businesses. In addition, our crisis management and disaster recovery procedures and business continuity plans may not be effective. Should any such hazards or risks occur, or should our insurance coverage be inadequate or unavailable, our businesses, financial condition and results of operations could be adversely affected.

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

We and our vendors have experienced and continue to experience a variety of cyber attacks, and we and our vendors expect to continue to experience cyber attacks going forward. Among other things, we and our vendors have experienced automated attempts to gain access to our public facing networks, brute force, SYN flood and distributed denial of service attacks, attempted malware infections, vulnerability scanning, ransomware attacks, spear-phishing campaigns, mass reconnaissance attempts, injection attempts, phishing, PHP injection and cross-site scripting. We also have seen an increase in attacks designed to obtain access to consumers' accounts using illegally obtained demographic information. Although the impact of such attacks has not been material to our operations or results of operations through December 31, 2018, we can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future. As we expand our consumer-oriented products and services, increase the amount and types of data we acquire, generate and use, increase the amount of information we make available to members, consumers and providers on mobile devices, expand our use of vendors, expand internationally and expand our use of social media, our exposure to these data security and related cybersecurity risks, including the risk of undetected attacks, damage, loss or unauthorized disclosure or access to and/or disruption of our systems and the customer, member, provider, employee, ACO, joint venture, vendor and other third party information they contain, increases, and the cost of attempting to protect against these risks also increases.

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

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

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

Our information systems are subject to damage or interruption from power outages, facility damage, computer and telecommunications failures, computer viruses, security breaches (including credit card or personally identifiable information breaches), cyber attacks, vandalism, catastrophic events and human error. If our information systems are damaged, fail to work properly or otherwise become unavailable, or if we are unable to successfully complete our planned consolidation of our PBM

claims adjudication platforms, we may incur substantial costs to repair or replace them, and may experience reputational damage, loss of critical information, customer disruption and interruptions or delays in our ability to perform essential functions and implement new and innovative services. In addition, compliance with changes in United States and foreign privacy and information security laws and standards may result in considerable expense due to increased investment in technology and the development of new operational processes.

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

Many aspects of our operations are dependent on our information systems and the information collected, processed, stored, and handled by these systems. We rely heavily on our computer systems to manage our ordering, pricing, point-of-sale, pharmacy fulfillment, inventory replenishment, claims processing, ExtraCare customer loyalty program, finance and other processes. Throughout our operations, we receive, retain and transmit certain confidential information, including PII and PHI, that our customers and clients provide to purchase products or services, enroll in programs or services, register on our websites, interact with our personnel, or otherwise communicate with us. In addition, for these operations, we depend in part on the secure transmission of confidential information over public networks.

We have many different information and other technology systems supporting our businesses (including as a result of our acquisitions). Our businesses depend in large part on these systems to adequately price our products and services; accurately establish reserves, process claims and report results of operations; and interact with providers, employer plan sponsors, members and vendors in an efficient and uninterrupted fashion. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Certain of our technology systems (including software) are older, legacy systems that are less flexible, less efficient and require a significant ongoing commitment of capital and human resources to maintain, protect and enhance them and to integrate them with our other systems. We must re-engineer and reduce the number of these systems to meet changing consumer and vendor preferences and needs, improve our productivity and reduce our operating expenses. We also need to develop or acquire new technology systems, contract with new vendors or modify certain of our existing systems to support the consumer-oriented products and services we are developing, operating and expanding and/or to meet current and developing industry and regulatory standards, including to keep pace with continuing changes in information processing technology and emerging cybersecurity risks and threats. If we fail to achieve these objectives, our ability to profitably grow our business and/or our results of operations may be adversely affected.

Our business strategy involves providing customers with differentiated, easy to use, secure products and solutions that use information to meet customer needs. The types of technology and levels of service that are acceptable to customers and members today will not necessarily be acceptable in the future, requiring us to anticipate and meet marketplace demands for technology. Our success therefore is dependent in large part on our ability, within the context of a limited budget of human resources and capital and our existing and future business relationships, to timely secure, integrate, develop, redesign and enhance our (or contract with vendors to provide) technology systems that support our business strategy initiatives and processes in a compliant, secure, and cost and resource efficient manner. Integration of our acquisitions increases these challenges, and we may not be successful in integrating various systems in a timely or cost-effective manner.

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

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

Our products are sold primarily through our sales personnel, who frequently work with independent brokers, consultants and agents who assist in the production and servicing of business. The independent brokers, consultants and agents generally are not dedicated to us exclusively and may frequently recommend and/or market health care benefits products of our competitors. Accordingly, we must compete intensely for their services and allegiance. Our sales could be adversely affected if we are unable to attract, retain or motivate sales personnel and third-party brokers, consultants and agents, or if we do not adequately

provide support, training and education to this sales network regarding our complex product portfolio, or if our sales strategy is not appropriately aligned across distribution channels. This risk is heightened as we develop, operate and expand our Consumer Health Products and Services products and services and our business model evolves to include a greater focus on consumers and direct-to-consumer sales, such as competing for sales on Insurance Exchanges.

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

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

***We also face other risks that could adversely affect our businesses, results of operations, financial condition and/or cash flows, which include:***

- Failure of our corporate governance policies or procedures, for example significant financial decisions being made at an inappropriate level in our organization;
- Inappropriate application of accounting principles or a significant failure of internal control over financial reporting, which could lead to a restatement of our results of operations and/or a deterioration in the soundness and accuracy of our reported results of operations; and
- Failure to adequately manage our run-off businesses and/or our regulatory and financial exposure to businesses we have sold, including Aetna's divested standalone Medicare Part D, domestic group life insurance, group disability insurance and absence management businesses.

## **Financial Risks**

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

As of December 31, 2018, we had \$115.2 billion of goodwill and other intangible assets. During the year ended December 31, 2018, we took \$6.1 billion of goodwill impairment charges related to our LTC reporting unit. Goodwill and indefinitely-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable. When evaluating goodwill for potential impairment, we compare the fair value of our reporting units to their respective carrying amounts. We estimate the fair value of our reporting units using a combination of a discounted cash flow method and a market multiple method. If the carrying amount of a reporting unit exceeds its estimated fair value, a goodwill impairment loss is recognized in an amount equal to the excess to the extent of the goodwill balance. Estimated fair values could change if, for example, there are changes in the business climate, changes in the competitive environment, adverse legal or regulatory actions or developments, changes in capital structure, cost of debt, interest rates, capital expenditure levels, operating cash flows or market capitalization. Because of the significance of our goodwill and intangible assets, any future impairment of these assets could require material noncash charges to our results of operations, which could have a material adverse effect on our financial condition and results of operations.

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

Our operations generate significant capital, and we have the ability to raise additional capital. The manner in which we deploy our capital, including investments in our businesses, our operations (such as information technology and other strategic and capital projects), dividends, acquisitions, share and/or debt repurchases, repayment of debt, reinsurance or other capital uses, impacts our financial strength, claims paying ability and credit ratings issued by recognized rating organizations. Credit ratings issued by nationally-recognized organizations are broadly distributed and generally used throughout our industries. Our ratings reflect each rating organization's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to our insureds. We believe our credit ratings and the financial strength and claims paying ability of

our principal insurance and HMO subsidiaries are important factors in marketing our Health Care Benefits products to certain of our customers.

Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future. In connection with the completion of the Aetna Acquisition, each of Standard & Poor's, Moody's and Fitch downgraded certain of our debt, financial strength and/or other credit ratings. Downgrades in our ratings could adversely affect our businesses, cash flows, financial condition and results of operations.

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

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

- Significantly reducing the value and/or liquidity of the debt securities we hold in our investment portfolio and creating realized capital losses that reduce our results of operations and/or unrealized capital losses that reduce our shareholders' equity;
- Keeping interest rates low on high-quality short-term or medium-term debt securities (such as we have experienced during recent years) and thereby materially reducing our net investment income and results of operations as the proceeds from securities in our investment portfolio that mature or are otherwise disposed of continue to be reinvested in lower yielding securities;
- Reducing the fair values of our investments if interest rates rise;
- Causing non-performance or defaults on their obligations to us by third parties, including customers, issuers of securities in our investment portfolio, mortgage borrowers and/or reinsurance and/or derivatives counterparties;
- Making it more difficult to value certain of our investment securities, for example if trading becomes less frequent, which could lead to significant period-to-period changes in our estimates of the fair values of those securities and cause period-to-period volatility in our net income and shareholders' equity;
- Reducing our ability to issue short-term debt securities at attractive interest rates, thereby increasing our interest expense and decreasing our results of operations; and
- Reducing our ability to issue other securities.

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

### **Risks Relating to Our Acquisition of Aetna**

***We have limited experience in the insurance and managed health care industry, which may hinder our ability to achieve our objectives as a combined company.***

We have limited experience operating an insurance and managed health care business, and are relying in large part on the existing management of Aetna to continue to manage our Health Care Benefits business. However, there is no assurance that we will be able to continue to retain the services of such management. If we fail to retain the existing management of Aetna, our ability to realize the anticipated benefits of the transaction may be adversely affected.

***The Aetna Acquisition may not be accretive, and may be dilutive, to our earnings per share, which may adversely affect our stock price.***

Although we currently project that the Aetna Acquisition will result in a number of benefits, including that it will be accretive to our earnings per share, changes in the estimates we use for these projections and the impact of future events and conditions, some of which we do not control, could cause actual results to be lower than these projections. In addition, future events and

conditions could decrease or delay the accretion that is currently projected or could result in dilution. These events and conditions include adverse changes in market conditions, changes in the regulatory environment, additional transaction and integration-related costs and other factors such as the failure to realize some or all of the anticipated benefits of the Aetna Acquisition. Any dilution of, decrease in or delay of any accretion to, our earnings per share could cause our stock price to decline or grow at a reduced rate.

***We may fail to successfully combine the businesses and operations of CVS Health and Aetna to realize the anticipated benefits and cost savings of the Aetna Acquisition within the anticipated timeframe or at all, which could adversely affect our stock price.***

The success of the Aetna Acquisition will depend, in part, on our ability to realize the anticipated benefits and cost savings from combining the businesses of CVS Health and Aetna. Our ability to realize these anticipated benefits and cost savings is subject to certain risks, including:

- Our ability to successfully combine the businesses of CVS Health and Aetna;
- whether the combined businesses will perform as expected;
- the possibility that we paid more for Aetna than the value we will derive from the acquisition;
- the reduction of our cash available for operations and other uses and the incurrence of indebtedness to finance the acquisition; and
- the assumption of known and unknown liabilities of Aetna.

If we are not able to successfully combine the businesses of CVS Health and Aetna within the anticipated time frame, the anticipated cost savings and other benefits of the Aetna Acquisition may not be realized fully or may take longer to realize than expected, the combined businesses may not perform as expected, and our stock price may be adversely affected.

Until the completion of the Aetna Acquisition, we and Aetna operated independently, and there can be no assurances that our respective businesses can be integrated successfully. It is possible that the integration process could result in the loss of key CVS Health or Aetna employees, the disruption of either company's or both companies' ongoing businesses or in unexpected integration issues, higher than expected integration costs and an overall post-completion integration process that takes longer than originally anticipated. Specifically, issues that must be addressed in integrating the operations of CVS Health and Aetna in order to realize the anticipated benefits of the Aetna Acquisition so the combined business performs as expected include, among other things:

- combining the companies' separate operational, financial, reporting and corporate functions;
- integrating the companies' technologies, products and services;
- identifying and eliminating redundant and underperforming operations and assets;
- harmonizing the companies' operating practices, employee development, compensation and benefit programs, internal controls and other policies, procedures and processes;
- addressing possible differences in business backgrounds, corporate cultures and management philosophies;
- consolidating the companies' corporate, administrative and information technology infrastructure;
- coordinating sales, distribution and marketing efforts;
- managing the movement of certain businesses and positions to different locations;
- maintaining existing agreements with customers, providers and vendors and avoiding delays in entering into new agreements with prospective customers, providers and vendors;
- operating in industry sectors in which we and our current management may have little or no experience;
- coordinating geographically dispersed organizations;
- consolidating offices of CVS Health and Aetna that are currently in or near the same location; and
- effecting the actions that are required by regulatory approvals we obtained in connection with completing the Aetna Acquisition.

In addition, at times, the attention of certain members of our management and our resources will be focused on the integration of the businesses of the two companies and diverted from day-to-day business operations, which may adversely affect our businesses.

***Our future results may be adversely impacted if we do not effectively manage our expanded operations following completion of the Aetna Acquisition.***

Following completion of the Aetna Acquisition our business is significantly larger than the size of either CVS Health's or Aetna's respective pre-transaction businesses. The combined company's ability to successfully manage this expanded business will depend, in part, upon management's ability to implement an effective integration of the two companies and its ability to manage a combined business with significantly larger size and scope with the associated increased costs and complexity. There can be no assurances that the management of the combined company will be successful or that the combined company will realize the expected operating efficiencies, cost savings and other benefits currently anticipated from the Aetna Acquisition. If we are not able to fully realize the expected operating efficiencies, cost savings and other benefits anticipated from the Aetna Acquisition, or such benefits take longer to realize than expected, our combined businesses may not perform as expected and our stock price may be adversely affected.

***We may have difficulty attracting, motivating and retaining executives and other key employees following completion of the Aetna Acquisition.***

Our future success will depend in part on our ability to retain key executives and other employees of Aetna. Uncertainty about the effect of the Aetna Acquisition on CVS Health and Aetna employees may have an adverse effect on the combined company and consequently the combined business. This uncertainty may impair our ability to attract, retain and motivate key personnel. Employee retention may be particularly challenging during the integration process, as employees of CVS Health and Aetna may experience uncertainty about their future roles in the combined business.

Furthermore, if key employees of CVS Health or Aetna depart or are at risk of departing, including because of issues relating to the uncertainty and difficulty of integration, financial security or a desire not to remain as employees of the combined business, we may have to incur significant costs in retaining such individuals or in identifying, hiring and retaining replacements for departing employees and may lose significant expertise and talent relating to the business of Aetna, and our ability to realize the anticipated benefits of the Aetna Acquisition may be materially and adversely affected. Accordingly, no assurance can be given that we will be able to attract or retain key employees of Aetna to the same extent that Aetna was able to attract or retain employees in the past.

***The Aetna integration process could disrupt our ongoing businesses and/or operations.***

Parties with which we do business may experience uncertainty associated with the Aetna Acquisition and/or the post-closing integration process, including with respect to current or future business relationships with the combined business. Our business relationships (including business relationships of our Health Care Benefits segment) may be subject to disruption as customers, members, manufacturers, providers, vendors and others may attempt to negotiate changes in existing business relationships or consider entering into business relationships with parties other than the combined business. These disruptions could have a material adverse effect on the businesses, financial condition, results of operations or prospects of one or more of the combined company's businesses, including a material adverse effect on our ability to realize the anticipated benefits of the Aetna Acquisition.

***Our indebtedness following completion of the Aetna Acquisition is substantially greater than our indebtedness on a stand-alone basis and greater than the combined indebtedness of CVS Health and Aetna existing prior to the announcement of the transaction. This increased level of indebtedness could adversely affect our business flexibility and increase our borrowing costs.***

In order to complete the Aetna Acquisition, we incurred acquisition-related debt financing of approximately \$45.0 billion and assumed Aetna's existing indebtedness with a fair value of approximately \$8.1 billion. Our substantially increased indebtedness and higher debt-to-equity ratio following completion of the Aetna Acquisition in comparison to that of CVS Health prior to the Aetna Acquisition has the effect, among other things, of reducing our flexibility to respond to changing business and economic conditions and increases our interest expense compared to pre Aetna Acquisition periods. In addition, the amount of cash required to service our increased indebtedness levels and thus the demands on our cash resources are greater than the amount of cash flows required to service the indebtedness of CVS Health or Aetna individually prior to the Aetna Acquisition. The increased levels of indebtedness could also reduce funds available to fund our efforts to combine our business with Aetna and realize expected benefits of the Aetna Acquisition and/or engage in investments in product development, capital expenditures, dividend payments, share repurchases and other activities and may create competitive disadvantages for us relative to other companies with lower debt levels.

***We will continue to incur significant integration-related costs in connection with the Aetna Acquisition.***

We expect to continue to incur significant non-recurring costs associated with combining the operations of CVS Health and Aetna. We expect to continue to incur significant integration-related costs related to formulating and implementing integration plans, including facilities and systems consolidation costs and employment-related costs. We continue to assess the magnitude of these costs, and additional unanticipated costs may be incurred in the integration of the two companies' businesses. We may not achieve the net benefit of such expenditures that we project associated with the elimination of duplicative costs, as well as the realization of other efficiencies related to the integration of our businesses in the near term, or at all. If we fail to realize the expected expense and other efficiencies we project, our results of operations, cash flows and stock price may be adversely affected.

**Risks Related to Our Acquisitions, Joint Ventures and International Operations**

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

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

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

We expect joint ventures to be an important part of our business model transformation and inorganic growth strategies. Joint ventures present risks that are different from acquisitions, including selection of appropriate joint venture parties, initial and ongoing governance of the joint venture, joint venture compliance activities (including compliance with applicable CMS requirements), growing the joint venture's business in a manner acceptable to all the parties, including other providers in the networks that include joint ventures, maintaining positive relationships among the joint venture parties and the customers, and member and business disruption that may occur upon joint venture termination.

***We may be unable to successfully integrate companies we acquire.***

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

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

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

***As a result of our expanded international operations, we face political, legal and compliance, operational, regulatory, economic and other risks that we do not face or are more significant than in our domestic operations.***

We significantly expanded our international operations as a result of the closing of the Aetna Acquisition in November 2018. As a result of our expanded international operations, we face political, legal, compliance, operational, regulatory, economic and other risks that we do not face or that are more significant than in our domestic operations. These risks vary widely by country and include varying regional and geopolitical business conditions and demands, government intervention and censorship, discriminatory regulation, nationalization or expropriation of assets and pricing constraints. Our international products need to meet country-specific customer and member preferences as well as country-specific legal requirements, including those related to licensing, privacy, data storage, location, protection and security.

Our international operations increase our exposure to, and require us to devote significant management resources to implement controls and systems to comply with, the privacy and data protection laws of non-U.S. jurisdictions and the anti-bribery, anti-corruption and anti-money laundering laws of the United States (including the FCPA) and the United Kingdom (including the UK Bribery Act) and similar laws in other jurisdictions. Implementing our compliance policies, internal controls and other systems upon our expansion into new countries and geographies may require the investment of considerable management time and management, financial and other resources over a number of years before any significant revenues or profits are generated. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or employees, restrictions or outright prohibitions on the conduct of our business, and significant brand and reputational harm. We must regularly reassess the size, capability and location of our global infrastructure and make appropriate changes, and must have effective change management processes and internal controls in place to address changes in our businesses and operations. Our success depends, in part, on our ability to anticipate these risks and manage these difficulties, and the failure to do so could have a material adverse effect on our businesses, results of operations, financial condition, brand, reputation and/or long-term growth.

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

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

### **Item 1B. Unresolved Staff Comments**

There are no unresolved SEC Staff Comments.

### **Item 2. Properties**

The Company's principal office is an owned building complex located in Woonsocket, Rhode Island, which totals approximately one million square feet. In addition, the Company leases corporate offices in Arizona, Illinois, Ohio, Pennsylvania, Texas, and Brazil.

#### **Pharmacy Services Segment**

As of December 31, 2018, the Pharmacy Services segment had the following properties:

- An owned mail service dispensing pharmacy located in Texas;
- Leased mail order dispensing pharmacies located in Hawaii, Illinois and Pennsylvania;
- Leased call centers located in California, Missouri, Pennsylvania, Tennessee and Texas;
- Approximately 40 leased on-site pharmacy stores, approximately 25 leased retail specialty pharmacy stores, approximately 20 specialty mail order pharmacies and approximately 90 branches for infusion and enteral services.

#### **Retail/LTC Segment**

As of December 31, 2018, the Retail/LTC segment had the following properties:

- Approximately 8,200 retail stores, of which approximately 4% were owned. Net selling space for retail stores was approximately 80.5 million square feet as of December 31, 2018. Approximately 25% of the store base was opened or significantly remodeled within the last five years;
- Approximately 1,700 retail pharmacies and approximately 80 clinics in Target stores;
- Nine owned distribution centers located in eight states and 13 leased distribution facilities located in twelve additional states and Brazil. The 22 distribution centers totaled approximately 10.4 million square feet as of December 31, 2018; and
- Six owned LTC pharmacies, approximately 150 leased LTC pharmacies in 46 states and one owned LTC repackaging facility.

In connection with certain business dispositions completed between 1991 and 1997, the Company continues to guarantee lease obligations for approximately 85 former stores. The Company is indemnified for these guarantee obligations by the respective purchasers. These guarantees generally remain in effect for the initial lease term and any extension thereof pursuant to a renewal option provided for in the lease prior to the time of the disposition. For additional information on these guarantees, see "Lease Guarantees" in Note 16 "Commitments and Contingencies" contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

#### **Health Care Benefits Segment**

The Health Care Benefits segment's principal office is an owned building complex that is approximately 1.7 million square feet in size and is located in Hartford, Connecticut. The Health Care Benefits segment also owns or leases other space in the greater Hartford area, Maryland, Pennsylvania, and various field locations in the United States and several other countries.

Management believes that the Company's owned and leased facilities are suitable and adequate to meet the Company's anticipated needs. At the end of the existing lease terms, management believes the leases can be renewed or replaced by

alternative space. For additional information on the amount of rental obligations for the Company's leases, see Note 6 "Leases" contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

### **Item 3. Legal Proceedings**

#### **I. Legal Proceedings**

The information contained in Note 16 "Commitments and Contingencies" of the "Notes to Consolidated Financial Statements" in the Annual Report is incorporated by reference herein.

#### **II. Environmental Matters**

Item 103 of SEC Regulation S-K requires disclosure of environmental legal proceedings with a governmental authority if management reasonably believes that the proceedings involve potential monetary sanctions of \$100,000 or more. The Company is in the process of negotiating with the New York State Department of Environmental Conservation to resolve claims of alleged historical noncompliance with hazardous waste regulations in connection with LTC pharmacies in the State of New York. These proceedings are not material to the Company's business or financial condition.

### **Item 4. Mine Safety Disclosures**

Not applicable.

## PART II

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

#### Market information

The Company’s common stock is listed on the New York Stock Exchange under the symbol “CVS.”

#### Holders of common stock

The information under the heading “Holders of Common Stock” in the Annual Report is incorporated by reference herein.

#### Dividends

The quarterly cash dividend declared by the Company’s Board of Directors (the “Board”) was \$0.50 per share in 2018 and 2017.

CVS Health has paid cash dividends every quarter since becoming a public company. Future dividends will depend on the Company’s earnings, capital requirements, financial condition and other factors considered relevant by the Board.

#### Issuer purchases of equity securities

The following share repurchase programs were authorized by the Board:

<i><u>In billions</u></i>			<b>Remaining as of</b>
<b><u>Authorization Date</u></b>	<b><u>Authorized</u></b>		<b><u>December 31, 2018</u></b>
November 2, 2016 (“2016 Repurchase Program”)	\$ 15.0	\$	13.9
December 15, 2014 (“2014 Repurchase Program”)	10.0		—

The share Repurchase Programs, each of which was effective immediately, permit the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase transactions, and/or other derivative transactions. The 2016 Repurchase Program can be modified or terminated by the Board at any time. During the three months ended December 31, 2018 the Company did not repurchase any shares of common stock.

See Note 12 “Shareholders’ Equity” of the “Notes to Consolidated Financial Statements” in the Annual Report, which is incorporated by reference herein, for additional information regarding the Company’s share repurchases.

## **Item 6. Selected Financial Data**

The selected consolidated financial data of CVS Health Corporation as of and for the periods indicated in the five-year period ended December 31, 2018, have been derived from the consolidated financial statements of CVS Health Corporation and is incorporated herein by reference to the information contained in the Annual Report under the heading “Five-Year Financial Summary.” The selected consolidated financial data should be read in conjunction with the consolidated financial statements and the audit reports of Ernst & Young LLP, which are incorporated by reference elsewhere in this Annual Report on Form 10-K.

## **Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations**

The information contained in “Management’s Discussion and Analysis of Financial Condition and Results of Operations” in the Annual Report, which includes the “Cautionary Statement Concerning Forward-Looking Statements” at the end of such section, is incorporated by reference herein.

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

The information contained in “Management’s Discussion and Analysis of Financial Condition and Results of Operations — Quantitative and Qualitative Disclosures About Market Risk” in the Annual Report is incorporated by reference herein.

## **Item 8. Financial Statements and Supplementary Data**

The information contained in “Consolidated Statements of Operations,” “Consolidated Statements of Comprehensive Income (Loss),” “Consolidated Balance Sheets,” “Consolidated Statements of Shareholders’ Equity,” “Consolidated Statements of Cash Flows,” “Notes to Consolidated Financial Statements,” and “Report of Independent Registered Public Accounting Firm” in the Annual Report, is incorporated by reference herein.

## **Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure**

None.

### **Item 9A. Controls and Procedures**

#### **Evaluation of disclosure controls and procedures**

The Company’s Chief Executive Officer and Chief Financial Officer, after evaluating the effectiveness of the design and operation of the Company’s disclosure controls and procedures (as defined in Rules 13a-15 (f) and 15d-15(f) under the Securities Exchange Act of 1934) as of December 31, 2018, have concluded that as of such date the Company’s disclosure controls and procedures were adequate and effective at a reasonable assurance level and designed to ensure that material information relating to the Company and its consolidated subsidiaries would be made known to such officers on a timely basis.

#### **Internal control over financial reporting**

The “Management’s Report on Internal Control Over Financial Reporting” and “Report of Independent Registered Public Accounting Firm” sections of the Annual Report are incorporated by reference herein. These sections contain management’s report on the Company’s internal control over financial reporting and the Independent Registered Public Accounting Firm’s report with respect to the effectiveness the Company’s internal control over financial reporting.

#### **Changes in internal control over financial reporting**

On November 28, 2018, the Company completed its acquisition of Aetna. In conducting its assessment of the effectiveness of the Company’s internal control over financial reporting as of December 31, 2018, management has elected to exclude Aetna from that assessment, as permitted under SEC rules. The Company is in the process of integrating the historical internal control over financial reporting of Aetna with the rest of the Company. Aetna’s operations are included in the Company’s 2018 consolidated financial statements for the period from November 28, 2018 to December 31, 2018 and represented 21% of the Company’s consolidated total assets as of December 31, 2018 and 3% of the Company’s consolidated total revenues for the year ended December 31, 2018.

Other than the foregoing, there has been no change in the Company's internal control over financial reporting identified in connection with the evaluation required by paragraph (d) of Rule 13a-15 or Rule 15d-15 that occurred during the fourth quarter ended December 31, 2018 that has materially affected, or is reasonably likely to materially affect, the Company's internal control over financial reporting.

#### **Item 9B. Other Information**

No events have occurred during the fourth quarter ended December 31, 2018 that would require disclosure under this item.

### **PART III**

#### **Item 10. Directors, Executive Officers and Corporate Governance**

The sections of the Proxy Statement under the captions "Committees of the Board," "Code of Conduct," "Audit Committee Report," "Biographies of our Incumbent Board Nominees," and "Section 16(a) Beneficial Ownership Reporting Compliance" are incorporated by reference herein.

##### **Executive Officers of the Registrant**

The following sets forth the name, age and biographical information for each of the Registrant's executive officers as of February 28, 2019. In each case the officer's term of office extends to the date of the board of directors meeting following the next annual meeting of stockholders of the Company. Previous positions and responsibilities held by each of the executive officers over the past five years or more are indicated below:

*Lisa G. Bisaccia*, age 62, Executive Vice President of CVS Health Corporation since March 2016 and Chief Human Resources Officer of CVS Health Corporation since January 2010; Senior Vice President of CVS Health Corporation from January 2010 through February 2016; Vice President, Human Resources of CVS Pharmacy, Inc. from September 2004 through December 2009. Ms. Bisaccia is also a member of the board of directors of Aramark, a leading global provider of food, facilities and uniform services.

*Eva C. Boratto*, age 52, Executive Vice President and Chief Financial Officer of CVS Health Corporation since November 2018; Executive Vice President - Controller and Chief Accounting Officer of CVS Health Corporation from March 2017 through November 2018; Senior Vice President - Controller and Chief Accounting Officer of CVS Health Corporation from July 2013 through February 2017; Senior Vice President of PBM Finance from July 2010 through June 2013.

*Troyen A. Brennan, M.D.*, age 64, Executive Vice President and Chief Medical Officer of CVS Health Corporation since November 2008; Executive Vice President and Chief Medical Officer of Aetna Inc. from February 2006 through November 2008.

*James D. Clark*, age 54, Senior Vice President - Controller and Chief Accounting Officer of CVS Health Corporation since November 2018; Vice President - Finance and Accounting of CVS Pharmacy, Inc. from September 2009 through October 2018.

*Joshua M. Flum*, age 49, Executive Vice President, Enterprise Strategy and Digital since November 2018; Executive Vice President, Corporate Strategy and Business Development of CVS Pharmacy, Inc. from June 2016 through October 2018; Executive Vice President - Pharmacy Services of CVS Pharmacy, Inc. from March 2015 through May 2016; Senior Vice President of Retail Pharmacy of CVS Pharmacy, Inc. from December 2010 through February 2015. Mr. Flum is a member of the board of directors of CreditRiskMonitor.com, Inc., a company that facilitates the analysis of corporate financial risk, mostly in the context of the extension of trade credit from one business to another.

*Kevin P. Hourican*, age 45, Executive Vice President of CVS Health Corporation and President of CVS Pharmacy since April 2018; Executive Vice President - Retail Pharmacy and Supply Chain of CVS Pharmacy, Inc. from June 2016 through March 2018; Senior Vice President, Field Operations and Supply Chain of CVS Pharmacy, Inc. from June 2014 through May 2016; Senior Vice President, Field Operations of CVS Pharmacy, Inc. from June 2012 through May 2014.

*Alan M. Lotvin, M.D.*, age 57, Executive Vice President - Transformation of CVS Health Corporation since June 2018; Executive Vice President - Specialty Pharmacy, CVS Caremark from November 2012 through May 2018.

*Karen S. Lynch*, age 56, Executive Vice President of CVS Health Corporation and President of Aetna since November 2018; President of Aetna from January 2015 to the present; Executive Vice President, Local and Regional Businesses of Aetna from February 2013 through December 2014; Executive Vice President, Head of Specialty Products of Aetna from July 2012 through January 2013. Ms. Lynch is a member of the board of directors of U.S. Bancorp, a banking and financial services company.

*Larry J. Merlo*, age 63, President and Chief Executive Officer of CVS Health Corporation since March 2011; President and Chief Operating Officer of CVS Health Corporation from May 2010 through March 2011; President of CVS Pharmacy from January 2007 through August 2011; Executive Vice President of CVS Health Corporation from January 2007 through May 2010; also a director of CVS Health Corporation since May 2010.

*Thomas M. Moriarty*, age 55, Executive Vice President and General Counsel of CVS Health Corporation since October 2012 and Chief Policy and External Affairs Officer since March 2017; Chief Strategy Officer from March 2014 through February 2017.

*Derica W. Rice*, age 54, Executive Vice President of CVS Health Corporation and President of CVS Caremark since March 2018; Executive Vice President of Global Services and Chief Financial Officer of Eli Lilly & Co. from May 2006 through December 2017. Mr. Rice was formerly a director of Target Corporation from September 2007 until January 2018, and is a candidate for election to the board of directors of The Walt Disney Company in March 2019.

*Jonathan C. Roberts*, age 63, Executive Vice President and Chief Operating Officer of CVS Health Corporation since March 2017; Executive Vice President of CVS Health Corporation and President of CVS Caremark from September 2012 through February 2017; Executive Vice President of CVS Health Corporation and Chief Operating Officer of CVS Caremark from October 2010 through August 2011.

## Item 11. Executive Compensation

The sections of the Proxy Statement under the captions “Non-Employee Director Compensation” and “Executive Compensation and Related Matters,” including “Compensation Discussion and Analysis,” “Letter from the Management Planning and Development Committee,” “Compensation Committee Report” and “Executive Compensation Tables” are incorporated by reference herein.

## Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

The sections of the Proxy Statement under the captions “Share Ownership of Directors and Certain Executive Officers” and “Share Ownership of Principal Stockholders” are incorporated by reference herein. Those sections contain information concerning security ownership of certain beneficial owners and management and related stockholder matters.

The following table summarizes information about the Company’s common stock that may be issued upon the exercise of options, warrants and rights under all of equity compensation plans as of December 31, 2018.

	Number of securities to be issued upon exercise of outstanding options, warrants and rights <sup>(1)(2)</sup>	Weighted average exercise price of outstanding options, warrants and rights	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in first column) <sup>(1)</sup>
	(a)	(b)	(c)
Equity compensation plans approved by stockholders <sup>(3)</sup>	27,102	\$ 77.51	25,927
Equity compensation plans not approved by stockholders <sup>(4)(5)</sup>	5,136	43.01	31,633
<b>Total</b>	<b>32,238</b>	<b>\$ 75.04</b>	<b>57,560</b>

(1) Shares in thousands.

(2) Consists of: (i) 18,597 shares of common stock underlying outstanding options, (ii) 1,435 shares of common stock issuable upon the exercise of outstanding stock appreciation rights (“SARs”) and (iii) 12,206 shares of common stock issuable on the vesting of outstanding restricted stock units, deferred stock units and performance stock units, assuming target level performance in the case of performance stock units. The number of shares included with respect to

outstanding SARs is the number of shares of the Company's common stock that would have been issued had the SARs been exercised based on the closing price per share of the Company's common stock on December 31, 2018, as reported on the NYSE, which was \$65.52.

- (3) Consists of the CVS Health 2017 Incentive Compensation Plan.
- (4) Consists of the Amended Aetna Inc. 2010 Stock Incentive Plan (the "Aetna Stock Plan").
- (5) Amount in column (c) consists of the maximum number of shares of the Company's common stock available for future issuance under the Aetna Stock Plan as of December 31, 2018.

The Aetna Stock Plan was last approved by Aetna's shareholders at Aetna's 2017 Annual Meeting on May 19, 2017. The Company elected to continue to grant awards under the Aetna Stock Plan to employees of Aetna and its subsidiaries following the completion of the Aetna Acquisition. The Aetna Stock Plan is designed to promote the Company's interests and those of its stockholders and to further align the interests of stockholders and employees by tying awards to total return to stockholders, enabling plan participants to acquire additional equity interests in the Company and providing compensation opportunities dependent upon the Company's performance. The Aetna Stock Plan has not been submitted to the Company's stockholders and will expire on May 21, 2020.

Under the Aetna Stock Plan, eligible participants can be granted stock options to purchase shares of the Company's common stock, SARs, time vesting and/or performance vesting incentive stock or incentive units and other stock based awards. As of December 31, 2018, the maximum number of shares of the Company's common stock that may be issued under the awards outstanding under the Aetna Stock Plan was 5.1 million shares, subject to adjustment for corporate transactions and 31.6 million shares remained available for future awards. If an award under the Aetna Stock Plan is paid solely in cash, no shares are deducted from the number of shares available for issuance under the Aetna Stock Plan.

### **Item 13. Certain Relationships and Related Transactions, and Director Independence**

The sections of the Proxy Statement under the captions "Independence Determinations for Directors" and "Related Person Transaction Policy" are incorporated by reference herein.

### **Item 14. Principal Accounting Fees and Services**

The section of the Proxy Statement under the caption "Item 2: Ratification of Appointment of Independent Registered Public Accounting Firm" is incorporated by reference herein.

## PART IV

### Item 15. Exhibits, Financial Statement Schedules

The following documents are filed as part of this Annual Report on Form 10-K:

1. Financial Statements. The following financial statements, related notes and report are incorporated by reference from the Annual Report in Item 8 hereof:

Consolidated Statements of Operations for the Years Ended December 31, 2018, 2017 and 2016

Consolidated Statements of Comprehensive Income (Loss) for the Years Ended December 31, 2018, 2017 and 2016

Consolidated Balance Sheets as of December 31, 2018 and 2017

Consolidated Statements of Cash Flows for the Years Ended December 31, 2018, 2017 and 2016

Consolidated Statements of Shareholders' Equity for the Years Ended December 31, 2018, 2017 and 2016

Notes to Consolidated Financial Statements

Report of Independent Registered Public Accounting Firm

2. Financial Statement Schedules. All financial statement schedules are omitted because they are not applicable, not required under the instructions, or the information is included in the consolidated financial statements or related notes.
3. Exhibits. The exhibits listed in the "Index to Exhibits" in this Item 15 are filed or incorporated by reference as part of this Annual Report on Form 10-K. Exhibits marked with an asterisk (\*) are management contracts or compensatory plans or arrangements. Exhibits other than those listed are omitted because they are not required to be listed or are not applicable. Pursuant to Item 601(b)(4)(iii) of Regulation S-K, the Registrant hereby agrees to furnish to the Securities and Exchange Commission a copy of any omitted instrument that is not required to be listed.

### INDEX TO EXHIBITS

<b>Exhibit</b>	<b>Description</b>
<b>2</b>	<b>Plan of acquisition, reorganization, arrangement, liquidation or succession</b>
2.1	<a href="#"><u>Agreement and Plan of Merger, dated as of May 20, 2015, among CVS Pharmacy, Inc., Tree Merger Sub, Inc. and Omnicare, Inc. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K filed May 21, 2015; Commission File No. 001-01011).</u></a>
2.2	<a href="#"><u>Agreement and Plan of Merger, dated as of December 3, 2017, among CVS Health Corporation, Hudson Merger Sub Corp. and Aetna Inc. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K filed December 5, 2017; Commission File No. 001-01011).</u></a>
2.3	<a href="#"><u>Master Transaction Agreement by and between Aetna Inc. and Hartford Life and Accident Insurance Company dated as of October 22, 2017.</u></a>
<b>3</b>	<b>Articles of Incorporation and Bylaws</b>
3.1	<a href="#"><u>Restated Certificate of Incorporation of the Registrant (incorporated by reference to Exhibit 3.1C of Registrant's Current Report on Form 8-K filed June 5, 2018; Commission File No. 001-01011).</u></a>
3.2	<a href="#"><u>By-laws of the Registrant, as amended and restated (incorporated by reference to Exhibit 3.2 to the Registrant's Current Report on Form 8-K filed June 5, 2018; Commission File No. 001-01011).</u></a>
<b>4</b>	<b>Instruments defining the rights of security holders, including indentures</b>
4.1	<a href="#"><u>Specimen common stock certificate (incorporated by reference to Exhibit 4.1 to the Registration Statement of the Registrant ((then known as CVS Corporation) as successor to Melville Corporation) on Form 8-B filed November 4, 1996; Commission File No. 001-01011).</u></a>
4.2	<a href="#"><u>Senior Indenture dated August 15, 2006, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed August 15, 2006; Commission File No. 001-01011).</u></a>
4.3	<a href="#"><u>Form of the Registrant's 2020 Floating Rate Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).</u></a>
4.4	<a href="#"><u>Form of the Registrant's 2021 Floating Rate Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).</u></a>

- 4.5 [Form of the Registrant's 2020 Note \(incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011\).](#)
- 4.6 [Form of the Registrant's 2021 Note \(incorporated by reference to Exhibit 4.4 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011\).](#)
- 4.7 [Form of the Registrant's 2023 Note \(incorporated by reference to Exhibit 4.5 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011\).](#)
- 4.8 [Form of the Registrant's 2025 Note \(incorporated by reference to Exhibit 4.6 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011\).](#)
- 4.9 [Form of the Registrant's 2028 Note \(incorporated by reference to Exhibit 4.7 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011\).](#)
- 4.10 [Form of the Registrant's 2038 Note \(incorporated by reference to Exhibit 4.8 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011\).](#)
- 4.11 [Form of the Registrant's 2048 Note \(incorporated by reference to Exhibit 4.9 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011\).](#)

**10 Material Contracts**

- 10.1 [Credit Agreement dated as of July 1, 2015, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent \(incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2015 \(Commission File No. 001-01011\).](#)
- 10.2 [Amendment No. 1 to Credit Agreement dated as of December 15, 2017, to the Credit Agreement dated as of July 1, 2015, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent \(incorporated by reference to Exhibit 10.5 to the Registrant's Current Report on Form 8-K filed December 19, 2017; Commission File No. 001-01-011\).](#)
- 10.3 [Amendment No. 2 to Credit Agreement dated as of May 17, 2018, to the Credit Agreement dated as of July 1, 2015, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent \(incorporated by reference to Exhibit 10.3 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01-011\).](#)
- 10.4 [Five Year Credit Agreement, dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent \(incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011\).](#)
- 10.5 [Amendment No. 1 to Five Year Credit Agreement dated as of December 15, 2017, to the Five Year Credit Agreement dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent \(incorporated by reference to Exhibit 10.3 to the Registrant's Current Report on Form 8-K filed December 19, 2017; Commission File No. 001-01011\).](#)
- 10.6 [Amendment No. 2 to Five Year Credit Agreement dated as of May 17, 2018, to the Five Year Credit Agreement dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent \(incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01011\).](#)
- 10.7 [Term Loan Agreement dated as of December 15, 2017, by and among the Registrant, the lenders party thereto and Barclays Bank PLC, as administrative agent \(incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed December 19, 2017; Commission File No. 001-01011\).](#)
- 10.8 [Amendment No. 1 to Term Loan Agreement dated as of May 17, 2018, to the Term Loan Agreement dated as of December 15, 2017, by and among the Registrant, the lenders party thereto and Barclays Bank PLC, as Administrative Agent \(incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01011\).](#)
- 10.9 [364-Day Credit Agreement dated as of May 17, 2018, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent \(incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01011\).](#)
- 10.10 [Five Year Credit Agreement dated as of May 17, 2018, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent \(incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01011\).](#)
- 10.11 [Bridge Facility Commitment Letter dated December 3, 2017, by and among the Registrant, Barclays Bank PLC, Goldman Sachs Bank USA, Goldman Sachs Lending Partners LLC, Bank of America, N.A., and Merrill Lynch, Pierce Fenner & Smith Incorporated \(incorporated by reference to Exhibit 2.2 to the Registrant's Current Report on Form 8-K filed December 5, 2017; Commission File No. 001-01011\).](#)

- 10.12 [Joinder to Bridge Facility Commitment Letter dated as of December 15, 2017, by and among the Registrant, Barclays Bank PLC, Goldman Sachs Bank USA, Goldman Sachs Lending Partners LLC, Bank of America, N.A., Merrill Lynch, Pierce, Fenner & Smith Incorporated, and each of the Additional Commitment Parties party thereto \(incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K filed December 19, 2017; Commission File No. 001-01011\).](#)
- 10.13 [364-Day Bridge Term Loan Agreement, dated October 26, 2018, by and among the Registrant, the lenders party thereto and Barclays Bank PLC, as Administrative Agent \(incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed October 26, 2018; Commission File No. 001-010011\).](#)
- 10.14\* [The Registrant's 1996 Directors Stock Plan, as amended and restated November 5, 2002 \(incorporated by reference to Exhibit 10.18 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 28, 2002; Commission File No. 001-01011\).](#)
- 10.15\* [Caremark Rx, Inc. 2004 Incentive Stock Plan \(incorporated by reference to Exhibit 99.2 of the Registrant's Registration Statement No. 333-141481 on Form S-8 filed March 22, 2007; Commission File No. 011-01011\).](#)
- 10.16\* [The Registrant's Supplemental Retirement Plan I for Select Senior Management, as amended and restated as of December 31, 2008 \(incorporated by reference to Exhibit 10.6 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2009; Commission File No. 011-01011\).](#)
- 10.17\* [The Registrant's 1997 Incentive Compensation Plan, as amended through December 31, 2008 \(incorporated by reference to Exhibit 10.8 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2009; Commission File No. 011-01011\).](#)
- 10.18\* [Form of Enterprise Non-Competition, Non-Disclosure and Developments Agreement between the Registrant and certain of the Registrant's executive officers \(incorporated by reference to Exhibit 10.25 of the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013; Commission File No. 001-01011\).](#)
- 10.19\* [The Registrant's 2010 Incentive Compensation Plan, as amended through January 15, 2013 \(incorporated by reference to Exhibit A to the Registrant's Definitive Proxy Statement on Form 14A filed March 27, 2015; Commission File No. 001-01011\).](#)
- 10.20\* [The Registrant's Deferred Stock Compensation Plan, as amended \(incorporated by reference to Exhibit 10.17 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011\).](#)
- 10.21\* [The Registrant's 2007 Employee Stock Purchase Plan, as amended \(incorporated by reference to Exhibit 10.20 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011\).](#)
- 10.22\* [Universal 409A Definition Document, as amended \(incorporated by reference to Exhibit 10.28 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011\).](#)
- 10.23\* [The Registrant's Deferred Compensation Plan, as amended \(incorporated by reference to Exhibit 10.19 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011\).](#)
- 10.24\* [The Registrant's Partnership Equity Program, as amended \(incorporated by reference to Exhibit 10.25 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011\).](#)
- 10.25\* [The Registrant's Performance-Based Restricted Stock Unit Plan, as amended \(incorporated by reference to Exhibit 10.27 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011\).](#)
- 10.26\* [The Registrant's 2017 Incentive Compensation Plan \(incorporated by reference to Exhibit A to the Registrant's Definitive Proxy Statement on Form 14A filed March 31, 2017; Commission File No. 001-01011\).](#)
- 10.27\* [The Registrant's Executive Incentive Plan, as amended \(incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011\).](#)
- 10.28\* [The Registrant's Long-Term Incentive Plan, as amended \(incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011\).](#)
- 10.29\* [Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant \(incorporated by reference to Exhibit 10.29 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011\).](#)
- 10.30\* [Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant \(incorporated by reference to Exhibit 10.30 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011\).](#)

- 10.31\* [Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant \(incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011\).](#)
- 10.32\* [Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement \(Pre-Tax\) \(incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011\).](#)
- 10.33\* [Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement \(Post-Tax\) \(incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011\).](#)
- 10.34\* [Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant \(incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018; Commission File No. 001-01011\).](#)
- 10.35\* [Form of Performance Stock Unit Agreement \(LTIP\) - Annual Grant between the Registrant and selected employees of the Registrant \(incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018; Commission File No. 001-01011\).](#)
- 10.36\* [The Registrant's 2018 Management Incentive Plan.](#)
- 10.37\* [The Registrant's Severance Plan for Non-Store Employees amended as of November 28, 2018.](#)
- 10.38\* [The Registrant's Performance-Based Restricted Stock Unit Program, as amended.](#)
- 10.39\* [Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant.](#)
- 10.40\* [Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant.](#)
- 10.41\* [Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant.](#)
- 10.42\* [Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement \(Pre-Tax\).](#)
- 10.43\* [Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement \(Post-Tax\) \(incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013; Commission File No. 001-01011\).](#)
- 10.44\* [Amended Aetna Inc. 2010 Stock Incentive Plan, as amended May 19, 2017 \(incorporated by reference to Exhibit 99.1 to the Registrant's Registration Statement on Form S-8 filed November 30, 2018; Commission File No. 001-01011\).](#)
- 10.45\* [Form of Aetna Inc. 2010 Stock Incentive Plan - Market Stock Unit Terms of Award.](#)
- 10.46\* [Form of Aetna Inc. 2010 Stock Incentive Plan - Performance Stock Unit Terms of Award \(2015\).](#)
- 10.47\* [Form of Aetna Inc. 2010 Stock Incentive Plan - Executive Restricted Stock Unit Terms of Award \(2015\).](#)
- 10.48\* [Form of Aetna Inc. 2010 Stock Incentive Plan - Stock Appreciation Right Terms of Award \(2015\).](#)
- 10.49\* [Amended and Restated Employment Agreement dated as of December 21, 2012 between the Registrant and Larry Merlo \(incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011\).](#)
- 10.50\* [Form of Non-Qualified Stock Option Agreement - Annual Grant between the Registrant and Larry Merlo \(incorporated by reference to Exhibit 10.37 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011\).](#)
- 10.51\* [Form of Restricted Stock Unit Agreement - Annual Grant between the Registrant and Larry Merlo \(incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011\).](#)
- 10.52\* [Amendment dated January 22, 2015 to Nonqualified Stock Option Agreements between the Registrant and Larry Merlo \(incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed January 23, 2015; Commission File No. 001-01011\).](#)
- 10.53\* [Change in Control Agreement dated December 22, 2008 between the Registrant and David Denton \(incorporated by reference to Exhibit 10.39 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2010; Commission File No. 001-01011\).](#)
- 10.54\* [Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and David Denton \(incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011\).](#)
- 10.55\* [Confidential Separation Agreement effective as of June 25, 2018, between the Registrant and David Denton \(incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended September 30, 2018; Commission File No. 001-01011\).](#)

- 10.56\* [Change in Control Agreement dated December 22, 2008 between the Registrant and Jonathan Roberts \(incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011\).](#)
- 10.57\* [Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and Jonathan Roberts \(incorporated by reference to Exhibit 10.34 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011\).](#)
- 10.58\* [Restricted Stock Unit Agreement - Annual Grant dated April 1, 2016 between the Registrant and Jonathan C. Roberts \(incorporated by reference to Exhibit 10.44 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011\).](#)
- 10.59\* [Restrictive Covenant Agreement dated May 20, 2016 between the Registrant and Jonathan C. Roberts \(incorporated by reference to Exhibit 10.45 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011\).](#)
- 10.60\* [Change in Control Agreement dated December 22, 2008 between the Registrant and Helena Foulkes \(incorporated by reference to Exhibit 10.43 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011\).](#)
- 10.61\* [Amendment dated as of December 31, 2012 to the Change in Control Agreement between the Registrant and Helena Foulkes \(incorporated by reference to Exhibit 10.44 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011\).](#)
- 10.62\* [Change in Control Agreement dated October 1, 2012 between the Registrant and Thomas Moriarity \(incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2015; Commission File No. 001-01011\).](#)
- 10.63\* [Restrictive Covenant Agreement dated June 1, 2014 between the Registrant and Thomas Moriarity \(incorporated by reference to Exhibit 10.2 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2015; Commission File No. 001-01011\).](#)
- 13 Annual Report to security holders, Form 10-Q or quarterly report to security holders**
- 13.1 [Portions of the 2018 Annual Report to Stockholders of CVS Health Corporation, which are specifically designated in this Annual Report on Form 10-K as being incorporated by reference.](#)
- 21 Subsidiaries of the registrant**
- 21.1 [Subsidiaries of CVS Health Corporation.](#)
- 23 Consents of experts and counsel**
- 23.1 [Consent of Ernst & Young LLP.](#)
- 31 Rule 13a-14(a)/15d-14(a) Certifications**
- 31.1 [Certification by the Chief Executive Officer.](#)
- 31.2 [Certification by the Chief Financial Officer.](#)
- 32 Section 1350 Certifications**
- 32.1 [Certification by the Chief Executive Officer.](#)
- 32.2 [Certification by the Chief Financial Officer.](#)
- 101 Interactive Data File**
- 101 The following materials from the CVS Health Corporation Annual Report on Form 10-K for the fiscal year ended December 31, 2018 formatted in Extensible Business Reporting Language (XBRL): (i) the Consolidated Statements of Operations, (ii) the Consolidated Statements of Comprehensive Income, (iii) the Consolidated Balance Sheets, (iv) the Consolidated Statements of Cash Flows, (v) the Consolidated Statements of Shareholders' Equity and (vi) the related Notes to Consolidated Financial Statements.

**Item 16. Form 10-K Summary**

None.



## Management's Discussion and Analysis of Financial Condition and Results of Operations

*The following discussion and analysis should be read in conjunction with the audited consolidated financial statements and Cautionary Statement Concerning Forward-Looking Statements that are included in this Annual Report.*

### Overview of Business

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is the nation's premier health innovation company helping people on their path to better health. Whether in one of its pharmacies or through its health services and plans, CVS Health is pioneering a bold new approach to total health by making quality care more affordable, accessible, simple and seamless. CVS Health is community-based and locally focused, engaging consumers with the care they need when and where they need it. The Company has more than 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 92 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year, expanding specialty pharmacy services, and a leading stand-alone Medicare Part D prescription drug plan. CVS Health also serves an estimated 38 million people through traditional, voluntary and consumer-directed health insurance products and related services, including rapidly expanding Medicare Advantage offerings. The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

On November 28, 2018 (the "Aetna Acquisition Date"), the Company acquired Aetna Inc. ("Aetna") for a combination of cash and CVS Health stock (the "Aetna Acquisition"). The Company acquired Aetna to help improve the consumer health care experience by combining Aetna's health care benefits products and services with CVS Health's more than 9,900 retail locations, approximately 1,100 walk-in medical clinics and integrated pharmacy capabilities with the goal of becoming the new, trusted front door to health care. Under the terms of the merger agreement, Aetna shareholders received \$145.00 in cash and 0.8378 CVS Health shares for each Aetna share. The transaction valued Aetna at approximately \$212 per share or approximately \$70 billion. Including the assumption of Aetna's debt, the total value of the transaction was approximately \$78 billion. The Company financed the cash portion of the purchase price through a combination of cash on hand and by issuing approximately \$45 billion of new debt, including senior notes and term loans (see "Liquidity and Capital Resources" later in this document). The consolidated financial statements for the year ended December 31, 2018 reflect Aetna's results subsequent to the Aetna Acquisition Date.

On October 10, 2018, the Company and Aetna entered into a consent decree with the United States Department of Justice (the "DOJ") that allowed the Company's proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone Medicare Part D prescription drug plans. As part of the agreement reached with the DOJ, Aetna entered into a purchase agreement with a subsidiary of WellCare Health Plans, Inc. for the divestiture of Aetna's standalone Medicare Part D prescription drug plans effective December 31, 2018. On November 30, 2018, Aetna completed the sale of its standalone Medicare Part D prescription drug plans. Aetna's standalone Medicare Part D prescription drug plans had an aggregate of approximately 2.3 million members as of December 31, 2018. Aetna will provide administrative services to, and will retain the financial results of, the divested plans through 2019.

As a result of the Aetna Acquisition, the Company added the Health Care Benefits segment, which is the equivalent of the former Aetna Health Care segment. Certain aspects of Aetna's operations, including products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, are included in the Company's Corporate/Other segment. The Company now has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other.

### 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, Medicare Part D services, clinical services, disease management services and medical spend management. The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D prescription drug plans ("PDPs"), Medicaid managed care plans, plans offered on public health insurance exchanges and private health insurance exchanges, other sponsors of health benefit plans and individuals throughout the United States. In addition, the Company is a national provider of drug benefits to eligible beneficiaries under the Medicare Part D prescription drug program. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and

branches for infusion and enteral nutrition services. During the year ended December 31, 2018, the Company's PBM filled or managed approximately 1.9 billion prescriptions on a 30-day equivalent basis.

### **Overview of the Retail/LTC Segment**

The Retail/LTC segment sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products, cosmetics and personal care products, provides health care services through its MinuteClinic® walk-in medical clinics and conducts long-term care ("LTC") pharmacy operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. Prior to January 2, 2018, the Retail/LTC segment also provided commercialization services under the name RxCrossroads®. The Company divested its RxCrossroads subsidiary on January 2, 2018. As of December 31, 2018, the Retail/LTC segment operated more than 9,900 retail locations, over 1,100 MinuteClinic® locations as well as online retail pharmacy websites, LTC pharmacies and onsite pharmacies. During the year ended December 31, 2018, the Retail/LTC segment filled approximately 1.3 billion prescriptions on a 30-day equivalent basis. In December 2018, the Company held approximately 26% of the United States retail pharmacy market.

### **Overview of the Health Care Benefits Segment**

The Health Care Benefits segment is one of the nation's leading diversified health care benefits providers, serving an estimated 38 million people as of December 31, 2018. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make better informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services, workers' compensation administrative services and health information technology products and services. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates.

### **Overview of the Corporate/Other Segment**

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

- Management and administrative expenses to support the overall operations of the Company, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments; and
- Products for which the Company no longer solicits or accepts new customers such as large case pensions and long-term care insurance products.

## Results of Operations

### Summary of Consolidated Financial Results

<i>In millions</i>	Year Ended December 31,			Change			
				2018 vs. 2017		2017 vs. 2016	
	2018	2017	2016	\$	%	\$	%
<b>Revenues:</b>							
Products	\$183,910	\$180,063	\$173,377	\$ 3,847	2.1 %	\$ 6,686	3.9 %
Premiums	8,184	3,558	3,069	4,626	130.0 %	489	15.9 %
Services	1,825	1,144	1,080	681	59.5 %	64	5.9 %
Net investment income	660	21	20	639	3,042.9 %	1	5.0 %
Total revenues	194,579	184,786	177,546	9,793	5.3 %	7,240	4.1 %
<b>Operating Costs:</b>							
Cost of products sold	156,447	153,448	146,533	2,999	2.0 %	6,915	4.7 %
Benefit costs	6,594	2,810	2,179	3,784	134.7 %	631	29.0 %
Goodwill impairments	6,149	181	—	5,968	3,297.2 %	181	— %
Operating expenses	21,368	18,809	18,448	2,559	13.6 %	361	2.0 %
Total operating costs	190,558	175,248	167,160	15,310	8.7 %	8,088	4.8 %
Operating income	4,021	9,538	10,386	(5,517)	(57.8)%	(848)	(8.2)%
Interest expense	2,619	1,062	1,078	1,557	146.6 %	(16)	(1.5)%
Loss on early extinguishment of debt	—	—	643	—	— %	(643)	(100.0)%
Other expense (income)	(4)	208	28	(212)	(101.9)%	180	642.9 %
Income before income tax provision	1,406	8,268	8,637	(6,862)	(83.0)%	(369)	(4.3)%
Income tax provision	2,002	1,637	3,317	365	22.3 %	(1,680)	(50.6)%
Income (loss) from continuing operations	(596)	6,631	5,320	(7,227)	(109.0)%	1,311	24.6 %
Loss from discontinued operations, net of tax	—	(8)	(1)	8	(100.0)%	(7)	700.0 %
Net income (loss)	(596)	6,623	5,319	(7,219)	(109.0)%	1,304	24.5 %
Net (income) loss attributable to noncontrolling interest	2	(1)	(2)	3	(300.0)%	1	(50.0)%
Net income (loss) attributable to CVS Health	\$ (594)	\$ 6,622	\$ 5,317	\$ (7,216)	(109.0)%	\$ 1,305	24.5 %

### Commentary - 2018 compared to 2017

#### Revenues

- Total revenues increased \$9.8 billion or 5.3% in 2018 compared to 2017. The increase in total revenues was due to a 2.7% increase in Pharmacy Services segment revenue, a 5.8% increase in Retail/LTC segment revenue and the impact of the Aetna Acquisition (primarily reflected in the Health Care Benefits segment) which occurred in November 2018.
- Please see “Segment Analysis” later in this document for additional information about the revenues of the Company’s segments.

#### Operating expenses (including goodwill impairments)

- Operating expenses increased \$8.5 billion or 44.9% in 2018 compared to 2017. The increase in operating expenses was primarily due to higher operating expenses in the Retail/LTC segment including increased goodwill impairment charges in 2018, the impact of the Aetna Acquisition and an increase in acquisition-related transaction and integration costs. The increase was partially offset by a lack of charges associated with store closures in 2018.
- Operating expenses as a percentage of total revenues was 14.1% in 2018, an increase of 380 basis points compared to 2017. The increase in operating expenses as a percentage of total revenues in 2018 was primarily due to the goodwill impairment charges in the Retail/LTC segment in 2018.
- Please see “Segment Analysis” later in this document for additional information about the operating expenses of the Company’s segments.

### *Operating income*

- Operating income decreased \$5.5 billion or 57.8% in 2018 compared to 2017. The decrease was primarily due to the increase in operating expenses described above, continued price compression in the Pharmacy Services segment and reimbursement pressure in the Retail/LTC segment. The decrease was partially offset by increased prescription volume, improved purchasing economics and the addition of Aetna.
- Please see “Segment Analysis” later in this document for additional information about the operating income of the Company’s segments.

### *Interest expense*

- Interest expense increased \$1.6 billion during 2018, primarily due to financing activity associated with the Aetna Acquisition. See Note 8 “Borrowings and Credit Agreements” to the consolidated financial statements for additional information.

### *Other expense (income)*

- Other expense decreased \$212 million during 2018, primarily due to 2017 reflecting a \$187 million loss on settlement of the Company’s defined benefit pension plans.

### *Income tax provision*

- 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 Company completed its assessment of the TCJA’s final impact in December 2018 and recorded an additional tax benefit of approximately \$100 million.
- The Company’s effective income tax rate was 142.4% in 2018 compared to 19.8% in 2017. The increase in the effective income tax rate was primarily due to the goodwill impairment charges in the Retail/LTC segment in 2018, the majority of which are not deductible for income tax purposes, and an income tax benefit of \$1.5 billion in 2017 which reflected the remeasurement of the Company’s net deferred income tax liabilities as a result of the enactment of the TCJA. The increase was partially offset by a lower federal corporate income tax rate in 2018 compared to the prior year as a result of the enactment of the TCJA, which reduced the corporate income tax rate in 2018 to 21% from 35% in 2017.

### *Loss from discontinued operations*

- In connection with certain business dispositions completed between 1991 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Linens ‘n Things, which filed for bankruptcy in 2008, and Bob’s stores, which filed for bankruptcy in 2016. The Company’s loss from discontinued operations includes lease-related costs required to satisfy its Linens ‘n Things and Bob’s Stores lease guarantees.
- The Company incurred a loss from discontinued operations, net of tax, of \$8 million in 2017. Results from discontinued operations were immaterial in 2018.
- See “Discontinued Operations” in Note 1 “Significant Accounting Policies” to the consolidated financial statements for additional information about discontinued operations and Note 16 “Commitments and Contingencies” to the consolidated financial statements for additional information about the Company’s lease guarantees.

## **Commentary - 2017 compared to 2016**

### *Revenues*

- Total revenues increased \$7.2 billion or 4.1% in 2017 compared to 2016. The increase in total revenues was due to a 8.9% increase in Pharmacy Services segment revenue, partially offset by a 2.1% decrease in Retail/LTC segment revenue.
- The increase in generic dispensing rates in 2017 negatively affected both the Pharmacy Services and Retail/LTC segment revenues in 2017 compared to 2016.
- Please see “Segment Analysis” later in this document for additional information about the revenues of the Company’s segments.

### *Operating expenses (including goodwill impairments)*

- Operating expenses increased \$542 million, or 2.9%, in 2017 compared to 2016. The increase in operating expenses primarily relates to (i) higher operating expenses in the Retail/LTC segment including an increase of \$181 million in charges associated with the closure of retail stores in connection with the Company’s enterprise streamlining initiative and a \$181 million goodwill impairment charge related to the RxCrossroads reporting unit; and (ii) higher operating expenses

in the Pharmacy Services segment due to 2016 reflecting the favorable impact of a reversal of an accrual of \$85 million in connection with a legal settlement. The increase was partially offset by lower acquisition-related transaction and integration costs due to the bulk of the integration costs related to the acquisition of Omnicare, Inc. (“Omnicare”) being incurred in 2016.

- Operating expenses as a percentage of total revenues was 10.3% in 2017, a decline of 10 basis points compared to 2016. The decline in operating expenses as a percentage of total revenues in 2017 was primarily due expense leverage from revenue growth.
- Please see “Segment Analysis” later in this document for additional information about the operating expenses of the Company’s segments.

#### *Operating income*

- Operating income decreased \$848 million or 8.2% in 2017 compared to 2016. The decrease was primarily driven by the previously announced restricted networks that excluded CVS Pharmacy, continued price compression in the Pharmacy Services segment, reimbursement pressure in the Retail/LTC segment and the increased operating expenses described above.
- Please see “Segment Analysis” later in this document for additional information about the operating income of the Company’s segments.

#### *Interest expense*

- Interest expense decreased \$16 million during 2017, primarily due to the Company’s debt issuance and debt tender offers that occurred in 2016 which resulted in overall more favorable interest rates on the Company’s long-term debt. See Note 8 “Borrowings and Credit Agreements” to the consolidated financial statements for additional information.

#### *Other expense (income)*

- Other expense increased \$180 million during 2017, primarily due to 2017 reflecting a \$187 million loss on settlement of the Company’s defined benefit pension plans.

#### *Loss on early extinguishment of debt*

- The loss on early extinguishment of debt of \$643 million in 2016 relates to the redemption of approximately \$4.2 billion aggregate principal amount of certain of the Company’s senior notes (see Note 8 “Borrowings and Credit Agreements” to the consolidated financial statements). As a result of the redemption, the Company paid a premium of \$583 million in excess of the debt principal, wrote off \$54 million of unamortized deferred financing costs and incurred \$6 million in fees.

#### *Income tax provision*

- The Company’s effective income tax rate was 19.8% in 2017 compared to 38.4% in 2016. The decrease in the effective income tax rate was primarily due to the provisional impact of the TCJA, including the revaluation of net deferred tax liabilities.
- As the 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 noncash income tax benefit of approximately \$1.5 billion in 2017.

#### *Loss from discontinued operations*

- Please see the *Commentary - 2018 compared to 2017* section above for additional information about the Company’s discontinued operations.
- The Company incurred losses from discontinued operations, net of tax, of \$8 million and \$1 million in 2017 and 2016, respectively.

## Outlook for 2019

The Company expects 2019 to be a transition year as it integrates the Aetna Acquisition and focuses on key pillars of its growth strategy. The Company believes that it is on track to exceed its 2020 target for synergies from the Aetna Acquisition. The Company also expects that the following challenges may have a disproportionate adverse impact on, and reduce, the operating income of its Pharmacy Services and Retail/LTC segments in 2019 compared to 2018:

- Ongoing pharmacy reimbursement pressure in the Pharmacy Services and Retail/LTC segments and reductions in the traditional offsets to those pressures, including a declining benefit from the introduction of new multi-source generic prescription drugs and lower benefits from generic dispensing rate increases;
- The reimbursement pressure in the Pharmacy Services segment is projected to be exacerbated by the cumulative effect on rebate guarantees of lower brand name drug price inflation and a modest 2019 selling season; and
- The Retail/LTC segment is projected to be impacted by structural and Company specific challenges in the long-term care space as well as the annualization of the Company's 2018 investment of a portion of the savings from the TCJA in wages and benefits.

The Company is taking specific actions designed to address these challenges and position it well in 2020 and beyond. These actions include new product and service initiatives in its Pharmacy Services and Retail/LTC segments, introducing a new PBM client contracting model, accelerating the action plan designed to improve the performance of the LTC business and initiating a new enterprise cost reduction effort. The Company also is continuing to evaluate its assets and the roles they play in enabling the Company's core strategies.

The Company's current expectations described above are forward-looking statements. Please see "Cautionary Statement Concerning Forward-Looking Statements" below 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 Company has three operating segments, Pharmacy Services, Retail/LTC and Health Care Benefits, as well as a Corporate/Other segment. The Company evaluates the performance of its operating segments based on operating income (loss) and operating income (loss) before the effect of (i) nonrecurring charges or gains and (ii) certain intersegment activities. The following is a reconciliation of the Company's segments total revenues and operating income (loss) to the consolidated financial statements:

<i>In millions</i>	Pharmacy Services <sup>(1)(2)</sup>	Retail/LTC <sup>(2)</sup>	Health Care Benefits <sup>(2)</sup>	Corporate/Other	Intersegment Eliminations <sup>(2)</sup>	Consolidated Totals
<b>2018</b>						
Total revenues <sup>(3)</sup>	\$ 134,128	\$ 83,989	\$ 5,549	\$ 606	\$ (29,693)	\$ 194,579
Operating income (loss) <sup>(4)(5)</sup>	4,699	620	276	(805)	(769)	4,021
<b>2017</b>						
Total revenues <sup>(7)</sup>	130,601	79,398	—	16	(25,229)	184,786
Operating income (loss) <sup>(4)(5)(7)</sup>	4,657	6,558	—	(936)	(741)	9,538
<b>2016</b>						
Total revenues <sup>(7)</sup>	119,965	81,100	—	18	(23,537)	177,546
Operating income (loss) <sup>(4)(5)(6)(7)</sup>	4,570	7,437	—	(900)	(721)	10,386

- (1) Total revenues of the Pharmacy Services segment include approximately \$11.4 billion, \$10.8 billion and \$10.5 billion of Retail Co-Payments for 2018, 2017 and 2016, respectively. See Note 1 "Significant Accounting Policies" to the consolidated financial statements for additional information about Retail Co-Payments.
- (2) Intersegment eliminations relate to intersegment revenue generating activities that occur between the Pharmacy Services segment and the Retail/LTC segment for 2018, 2017 and 2016. Effective November 28, 2018, intersegment eliminations also relate to intersegment revenue generating activities that occur between the Health Care Benefits segment, the Pharmacy Services segment and/or the Retail/LTC segment.
- (3) Corporate/Other segment revenues for 2018 include interest income of \$536 million related to the proceeds of the \$40 billion principal amount of unsecured floating rate notes and unsecured fixed rate senior notes the Company issued on March 9, 2018 (collectively, the "2018 Notes"). This amount is for the period prior to the close of the Aetna Acquisition, which occurred on November 28, 2018.
- (4) Retail/LTC segment operating income for 2018, 2017 and 2016 includes \$7 million, \$34 million and \$281 million, respectively, of acquisition-related integration costs. The integration costs in 2018 and 2017 are related to the acquisition of Omnicare. The integration costs in 2016 are related to the acquisitions of Omnicare and the pharmacy and clinic businesses of Target Corporation ("Target"). Retail/LTC segment operating income for 2018 and 2017 also includes goodwill impairment charges of \$6.1 billion related to the LTC reporting unit and \$181 million related to the RxCrossroads reporting unit, respectively. In addition, Retail/LTC segment operating income for 2017 and 2016 includes \$215 million and \$34 million, respectively, of charges associated with store rationalization and asset impairment charges in connection with planned store closures related to the Company's enterprise streamlining initiative. Retail/LTC segment operating income for 2018 also includes a \$43 million loss on impairment of long-lived assets primarily related to the impairment of property and equipment and an \$86 million loss on the divestiture of the Company's RxCrossroads subsidiary.
- (5) Corporate/Other segment operating loss for 2018, 2017 and 2016 includes \$485 million, \$40 million and \$10 million, respectively, of divestiture and acquisition-related transaction and integration costs included in operating expenses in the consolidated statements of operations. The transaction and integration costs in 2018 are related to the acquisitions of Aetna and Omnicare. The transaction and integration costs in 2017 are related to the acquisitions of Aetna and Omnicare and the divestiture of RxCrossroads. The integration costs in 2016 are related to the acquisitions of Omnicare and the pharmacy and clinic businesses of Target.
- (6) Pharmacy Services segment operating income for 2016 includes the reversal of an accrual of \$88 million in connection with a legal settlement.
- (7) Amounts revised to reflect the reclassification of interest income from interest expense, net to net investment income within total revenues to conform with insurance company presentation which increased total revenues and operating income by \$21 million and \$20 million in 2017 and 2016, respectively.

## Pharmacy Services Segment

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

<i>In millions</i>	Year Ended December 31,			Change			
	2018	2017	2016	2018 vs. 2017		2017 vs. 2016	
				\$	%	\$	%
<b>Revenues:</b>							
Products	\$ 130,264	\$ 126,770	\$ 116,639	\$ 3,494	2.8 %	\$ 10,131	8.7%
Premiums	3,361	3,558	3,069	(197)	(5.5)%	489	15.9%
Services	490	268	255	222	82.8 %	13	5.1%
Net investment income <sup>(1)</sup>	13	5	2	8	160.0 %	3	150.0%
Total revenues	134,128	130,601	119,965	3,527	2.7 %	10,636	8.9%
Cost of products sold	125,107	121,799	111,949	3,308	2.7 %	9,850	8.8%
Benefit costs	2,805	2,810	2,179	(5)	(0.2)%	631	29.0%
Operating expenses <sup>(2)</sup>	1,517	1,335	1,267	182	13.6 %	68	5.4%
Operating expenses % of revenues	1.1%	1.0%	1.1%				
Operating income <sup>(1)</sup>	\$ 4,699	\$ 4,657	\$ 4,570	\$ 42	0.9 %	\$ 87	1.9%
Operating income % of revenues	3.5%	3.6%	3.8%				
<b>Revenues (by distribution channel): <sup>(8)</sup></b>							
Pharmacy network <sup>(3)(4)</sup>	\$ 83,261	\$ 80,891	\$ 73,686	\$ 2,370	2.9 %	\$ 7,205	9.8%
Mail choice <sup>(5)</sup>	46,934	45,709	42,783	1,225	2.7 %	2,926	6.8%
Other <sup>(4)</sup>	3,920	3,996	3,494	(76)	(1.9)%	502	14.4%
<b>Pharmacy claims processed: <sup>(6)(7)</sup></b>							
Total	1,889.8	1,781.9	1,639.2	107.9	6.1 %	142.7	8.7%
Pharmacy network <sup>(3)</sup>	1,601.4	1,516.7	1,387.7	84.7	5.6 %	129	9.3%
Mail choice <sup>(5)</sup>	288.4	265.2	251.5	23.2	8.7 %	13.7	5.4%
<b>Generic dispensing rate: <sup>(6)(7)</sup></b>							
Total	87.3%	87.0%	85.9%				
Pharmacy network <sup>(3)</sup>	87.9%	87.7%	86.7%				
Mail choice <sup>(5)</sup>	83.9%	83.1%	81.4%				
Mail choice penetration rate <sup>(6)(7)</sup>	15.3%	14.9%	15.3%				

(1) Amounts revised to reflect the reclassification of interest income from interest expense, net to net investment income within revenues to conform with insurance company presentation which increased both net investment income and operating income by \$5 million and \$2 million in 2017 and 2016, respectively.

(2) Pharmacy Services segment operating expenses in 2016 include the reversal of an accrual of \$88 million in connection with a legal settlement.

(3) Pharmacy network revenues, pharmacy network claims processed and pharmacy network generic dispensing rate do not include Maintenance Choice<sup>®</sup> activity, which is included within the mail choice category. Pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including the Company's retail pharmacies and LTC pharmacies, but excluding Maintenance Choice activity.

(4) Amounts revised for 2017 and 2016 to reflect the reclassification of Medicare Part D premium revenues from pharmacy network revenues to other revenues.

(5) Mail choice is defined as claims filled at a Pharmacy Services mail facility, which includes specialty mail claims inclusive of Specialty Connect<sup>®</sup> claims picked up at a CVS Pharmacy retail store, as well as prescriptions filled at the Company's retail pharmacies under the Maintenance Choice program, which 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.

(6) Includes the 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.

(7) The pharmacy claims processed, generic dispensing rate and mail choice penetration rate in 2016 have been revised to convert 90-day prescriptions to the equivalent of three 30-day prescriptions.

(8) Excludes net investment income.

## *Commentary - 2018 compared to 2017*

### *Revenues*

- Total revenues increased \$3.5 billion, or 2.7%, to \$134.1 billion in 2018 compared to 2017. The increase was primarily due to increased total pharmacy claims volume, partially offset by continued client pricing pressures.
- As you review the Pharmacy Services segment's performance in this area, you should consider the following important information about the business:
  - The Company's mail choice claims processed, on a 30-day equivalent basis, increased 8.7% to 288.4 million claims in 2018 compared to 265.2 million claims in 2017. The increase in mail choice claims was primarily driven by the continued adoption of Maintenance Choice offerings and an increase in specialty pharmacy claims.
  - During 2018, the average revenue per mail choice claim, on a 30-day equivalent basis, decreased by 5.6% compared to 2017 as a result of price compression.
  - The Company's pharmacy network claims processed, on a 30-day equivalent basis, increased 5.6% to approximately 1.6 billion claims in 2018 compared to approximately 1.5 billion claims in 2017. The increase in the pharmacy network claim volume was primarily due to net new business.
  - During 2018, the average revenue per pharmacy network claim processed, on a 30-day equivalent basis, decreased 2.7% compared to 2017 as a result of continued price compression.
  - The Company's total generic dispensing rate increased to 87.3% in 2018 compared to 87.0% in 2017. The continued increase in the Company's generic dispensing rate was primarily due to the impact of new generic drug introductions and the Company's ongoing efforts to encourage plan members to use generic drugs when they are available and clinically appropriate. The Company believes its generic dispensing rate will continue to increase in future periods, albeit at a slower pace. This increase will be affected by, among other things, the number of new brand and generic drug introductions and the Company's success at encouraging plan members to utilize generic drugs when they are available and clinically appropriate.

### *Operating expenses*

- Operating expenses in the Pharmacy Services segment include selling, general and administrative expenses, depreciation and amortization related to selling, general and administrative activities and administrative payroll, employee benefits and occupancy costs.
- Operating expenses increased \$182 million, or 13.6%, in 2018 compared to 2017. The year over year increase in operating expenses was primarily due to:
  - Growth in the business, including acquisitions; and
  - The reinstatement of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010's (as amended, collectively, the "ACA's") health insurer fee ("HIF") in 2018;
  - Partially offset by the realization of partially reserved receivables in 2017 which reduced operating expenses.
- Operating expenses as a percentage of total revenues remained relatively consistent at 1.1% and 1.0% in 2018 and 2017, respectively.

### *Operating income*

- Operating income increased \$42 million, or 0.9%, to \$4.7 billion in 2018 compared to 2017. The increase in operating income was primarily due to increased claims volume and improved purchasing economics, partially offset by continued price compression and the increased operating expenses described above.
- 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. 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.

## *Commentary - 2017 compared to 2016*

### *Revenues*

- Total revenues increased \$10.6 billion, or 8.9%, to \$130.6 billion in 2017 compared to 2016. The increase was primarily due to growth in pharmacy network and specialty pharmacy volume as well as brand name drug price inflation, partially offset by continued price compression and increased generic dispensing.
- As you review the Pharmacy Services segment's performance in this area, you should consider the following important information about the business:
  - The Company's mail choice claims processed, on a 30-day equivalent basis, increased 5.4% to 265.2 million claims in 2017 compared to 251.5 million claims in 2016.
  - During 2017, the Company's average revenue per mail choice claim, on a 30-day equivalent basis, increased by 1.7% compared to 2016. The increase was primarily due to growth in specialty pharmacy and brand name drug price inflation.
  - The Company's pharmacy network claims processed, on a 30-day equivalent basis, increased 9.3% to approximately 1.5 billion claims in 2017 compared to approximately 1.4 billion claims in 2016. The increase was primarily due to increased volume from net new business.
  - During 2017, the average revenue per pharmacy network claim processed remained flat on a 30-day equivalent basis.
  - The Company's total generic dispensing rate increased to 87.0% in 2017 compared to 85.9% in 2016. The increase in the Company's generic dispensing rate was primarily due to the impact of new generic drug introductions, and the Company's ongoing efforts to encourage plan members to use generic drugs when they are available and clinically appropriate.

### *Operating expenses*

- Operating expenses increased \$68 million, or 5.4%, in 2017 compared to 2016. The year over year increase in operating expenses was primarily due to an \$88 million reversal of an accrual in connection with a legal settlement in 2016 and an increase in costs associated with the growth of the business. The increase was partially offset by the realization of partially reserved receivables in 2017 which reduced operating expenses.
- Operating expenses as a percentage of revenues remained relatively consistent at 1.0% and 1.1% of revenues in 2017 and 2016, respectively.

### *Operating income*

- Operating income increased \$87 million, or 1.9%, to \$4.7 billion in 2017 compared to 2016. The increase in operating income was primarily due to growth in specialty pharmacy, higher generic dispensing and favorable purchasing economics, partially offset by price compression and the increased operating expenses described above.

## Retail/LTC Segment

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

<i>In millions</i>	Year Ended December 31,			Change			
				2018 vs. 2017		2017 vs. 2016	
	2018	2017	2016	\$	%	\$	%
<b>Revenues</b>							
Products	\$ 83,175	\$78,522	\$80,275	\$ 4,653	5.9 %	\$ (1,753)	(2.2)%
Services	814	876	825	(62)	(7.1)%	51	6.2 %
Total revenues	83,989	79,398	81,100	4,591	5.8 %	(1,702)	(2.1)%
Cost of products sold <sup>(1)</sup>	59,906	56,066	57,339	3,840	6.8 %	(1,273)	(2.2)%
Operating expenses <sup>(2)(3)(4)(5)(6)</sup>	23,463	16,774	16,324	6,689	39.9 %	450	2.8 %
Operating expenses % of revenues	27.9%	21.1 %	20.1 %				
Operating income <sup>(1)(2)(3)(4)(5)(6)</sup>	\$ 620	\$ 6,558	\$ 7,437	\$ (5,938)	(90.5)%	\$ (879)	(11.8)%
Operating income % of revenues	0.7%	8.3 %	9.2 %				
<b>Revenues (by major goods/service line):</b>							
Pharmacy	\$ 64,179	\$59,528	\$60,838	\$ 4,651	7.8 %	\$ (1,310)	(2.2)%
Front Store	19,055	18,769	19,123	286	1.5 %	(354)	(1.9)%
Other	755	1,101	1,139	(346)	(31.4)%	(38)	(3.3)%
Prescriptions filled <sup>(7)</sup>	1,339.1	1,230.5	1,223.5	108.6	8.8 %	7.0	0.6 %
<b>Revenue increase (decrease):</b>							
Total	5.8%	(2.1)%	12.6 %				
Pharmacy	7.8%	(2.2)%	15.9 %				
Front Store	1.5%	(1.9)%	0.3 %				
Total prescription volume <sup>(7)</sup>	8.8%	0.6 %	18.6 %				
<b>Same store sales increase (decrease): <sup>(8)</sup></b>							
Total	6.0%	(2.6)%	1.9 %				
Pharmacy	7.9%	(2.6)%	3.2 %				
Front Store	0.5%	(2.6)%	(1.5)%				
Prescription volume <sup>(7)</sup>	9.1%	0.4 %	3.6 %				
Generic dispensing rate	87.5%	87.3 %	85.7 %				

- (1) Cost of products sold and operating income for 2017 include \$2 million of acquisition-related integration costs related to the acquisition of Omnicare.
- (2) Operating expenses and operating income in 2018, 2017 and 2016 include \$7 million, \$32 million and \$235 million, respectively, of acquisition-related integration costs. In 2018 and 2017, the integration costs related to the acquisition of Omnicare. In 2016, the integration costs related to the acquisitions of Omnicare and the pharmacy and clinic businesses of Target.
- (3) Operating expenses and operating income for 2018 and 2017 include goodwill impairment charges of \$6.1 billion related to the LTC reporting unit and \$181 million related to the RxCrossroads reporting unit, respectively.
- (4) Operating expenses and operating income for 2017 and 2016 include \$215 million and \$34 million, respectively, of charges associated with store rationalization and asset impairment charges in connection with planned store closures related to the Company's enterprise streamlining initiative.
- (5) Operating expenses and operating income for 2018 include a \$43 million loss on impairment of long-lived assets primarily related to the impairment of property and equipment.
- (6) Operating expenses and operating income for 2018 include an \$86 million loss on the divestiture of the Company's RxCrossroads subsidiary.
- (7) Includes the adjustment to convert 90-day, non-specialty 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.
- (8) Same store sales and prescription volume exclude revenues from MinuteClinic, and revenue and prescriptions from stores in Brazil, LTC operations and commercialization services.

## *Commentary - 2018 compared to 2017*

### *Revenues*

- Total revenues increased approximately \$4.6 billion, or 5.8%, to \$84.0 billion in 2018 compared to 2017. The increase was primarily driven by increased prescription volume and brand name drug price inflation, partially offset by continued reimbursement pressure and the impact of recent generic introductions.
- As you review the Retail/LTC segment's performance in this area, you should consider the following important information about the business:
  - Front store same store sales increased 0.5% in 2018 compared to 2017. Front store sales in 2018 continued to benefit from increases in health product sales.
  - Pharmacy same store sales increased 7.9% in 2018 compared to 2017. The increase was driven by the 9.1% increase in pharmacy same store prescription volumes on a 30-day equivalent basis due to (i) continued adoption of patient care programs, (ii) collaborations with PBMs, and (iii) the Company's preferred status in a number of Medicare Part D networks during 2018. The increase was also due to the impact of year over year brand name drug price inflation that occurred primarily in the first three months of 2018.
  - Pharmacy revenue continues to be adversely affected by the conversion of brand name drugs to equivalent generic drugs, which typically have a lower selling price. The generic dispensing rate grew to 87.5% in 2018 compared to 87.3% in 2017. In addition, pharmacy revenue growth has also been negatively affected by continued reimbursement pressure.
  - 2017 revenues include approximately \$0.4 billion related to the Company's RxCrossroads subsidiary which was sold on January 2, 2018.
  - Pharmacy revenue growth has been adversely affected by industry challenges in the LTC business, such as continuing lower occupancy rates at skilled nursing facilities, as well as the deteriorating financial health of many skilled nursing facilities which resulted in a number of customer bankruptcies in 2018.
  - Pharmacy revenue in 2018 continued to benefit from the Company's ability to attract and retain managed care customers and the increased use of pharmaceuticals by an aging population as the first line of defense for health care.

### *Operating expenses (including goodwill impairments)*

- 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 \$6.7 billion, or 39.9%, in 2018 compared to 2017. The increase in operating expenses in 2018 was primarily due to:
  - A goodwill impairment charge of \$6.1 billion in 2018 in the LTC reporting unit (see Note 5 "Goodwill and Other Intangibles" to the consolidated financial statements), as compared to a \$181 million goodwill impairment charge in the RxCrossroads reporting unit recorded in 2017 in connection with the upcoming sale of RxCrossroads. See the discussion of goodwill under "Critical Accounting Policies" later in this document;
  - An \$86 million pre-tax loss on the sale of the RxCrossroads subsidiary in 2018;
  - A \$43 million impairment of long-lived assets in 2018; and
  - An increase in operating expenses due to (i) the investment of a portion of the savings from the TCJA in wages and benefits, (ii) increased prescription volume described previously, (iii) incremental costs associated with operating more stores and (iv) other investments in the business to drive revenue growth;
  - Partially offset by lower operating expenses as a result of a lack of charges associated with store closures in 2018, for which the Company incurred \$215 million in connection with its enterprise streamlining initiative in 2017; and
  - A decrease in hurricane-related expenses of \$25 million in 2018 compared to 2017.
- Operating expenses as a percentage of total revenues were 27.9% in 2018 compared to 21.1% in 2017. The increase in operating expenses as a percentage of total revenues was driven by the increased goodwill impairment charges in 2018.

### *Operating income*

- Operating income decreased \$5.9 billion, or 90.5%, to approximately \$620 million in 2018 compared to 2017. The decrease in operating income was driven primarily by the increased operating expenses described above.

- As you review the Retail/LTC segment's performance in this area, you should consider the following important information about the business:
  - The Company's pharmacy operating income has been adversely affected by the efforts of managed care organizations, PBMs and governmental and other third-party payors to reduce their prescription drug costs, including the use of restrictive networks, as well as changes in the mix of business within the pharmacy portion of the Retail/LTC Segment. If the reimbursement pressure accelerates, the Company may not be able to grow revenues, and its operating income could be adversely affected.
  - The increased use of generic drugs has positively impacted the Company's 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 Company realizes from brand to generic product conversions.

### ***Commentary - 2017 compared to 2016***

#### *Revenues*

- Total revenues decreased approximately \$1.7 billion, or 2.1%, to \$79.4 billion in 2017 compared to 2016. The decrease was primarily due to a decline in same store sales as a result of the previously-announced marketplace changes that restrict CVS Pharmacy from participating in certain networks.
- As you review the Retail/LTC segment's performance in this area, you should consider the following important information about the business:
  - Front store same store sales declined 2.6% in 2017 compared to 2016 and were negatively impacted approximately 30 basis points due to the absence of leap day in 2017. The decrease was primarily driven by softer customer traffic and efforts to rationalize promotional strategies, partially offset by an increase in basket size.
  - Pharmacy same store sales declined 2.6% in 2017 compared to 2016. Pharmacy same store sales were negatively impacted by approximately 390 basis points due to recent generic introductions. Same store prescription volumes increased 0.4%, despite the approximately 420 basis point negative impact from previously-discussed marketplace changes that restrict CVS Pharmacy from participating in certain networks.
  - Pharmacy revenue continues to be negatively impacted by the conversion of brand name drugs to equivalent generic drugs, which typically have a lower selling price. The generic dispensing rate grew to 87.3% in 2017 compared to 85.7% in 2016. In addition, pharmacy revenue growth has also been negatively affected by the mix of drugs sold, continued reimbursement pressure and the lack of significant new brand name drug introductions.
  - Pharmacy revenue in 2017 continued to benefit from the Company's ability to attract and retain managed care customers, and the increased use of pharmaceuticals by an aging population as the first line of defense for health care.

#### *Operating expenses (including goodwill impairment)*

- Operating expenses increased \$450 million, or 2.8% in 2017. The increase in operating expenses in 2017 was due primarily to:
  - An increase of \$181 million in charges associated with the closure of retail stores in connection with the Company's enterprise streamlining initiative;
  - A goodwill impairment charge of \$181 million related to the RxCrossroads reporting unit, which was subsequently sold on January 2, 2018;
  - Hurricane related costs of \$55 million; and
  - Costs associated with new store openings
- Operating expenses as a percentage of total revenues were 21.1% in 2017 compared to 20.1% in 2016. The increase in 2017 was primarily due to a decline in expense leverage with the loss of business from the previously discussed marketplace changes that restrict CVS Pharmacy from participating in certain networks.

#### *Operating income*

- Operating income decreased \$879 million, or 11.8%, to approximately \$6.6 billion in 2017 compared to 2016. The decrease in operating income was driven primarily by the increased operating expenses described above and reimbursement pressure.

## Health Care Benefits Segment

On November 28, 2018, the Company completed the Aetna Acquisition. The Health Care Benefits segment is the equivalent of the former Aetna Health Care segment.

The following table summarizes the Health Care Benefits segment's performance for the period from November 28, 2018 to December 31, 2018:

### In millions

Revenues:	
Products	\$ 164
Premiums	4,819
Services	521
Net investment income	45
Total revenues	5,549
Cost of products sold	147
Benefit costs	3,873
Operating expenses	1,253
Operating income	\$ 276

Revenues and operating income for the Health Care Benefits segment include results for the period from November 28, 2018 to December 31, 2018 and therefore are not directly comparable to the former Aetna Health Care segment results for the fourth quarter of 2017.

Health Care Benefits segment medical membership as of December 31, 2018 was as follows:

<u>In thousands</u>	<u>Insured</u>	<u>ASC<sup>(1)</sup></u>	<u>Total</u>
Medical membership:			
Commercial	3,871	13,888	17,759
Medicare Advantage	1,758	—	1,758
Medicare Supplement	793	—	793
Medicaid	1,128	663	1,791
Total medical membership	7,550	14,551	22,101

(1) Represents self-insured membership under Administrative Services Contracts.

### *Medical Membership*

Medical membership as of December 31, 2018 remained relatively consistent compared with December 31, 2017, reflecting decreases in Commercial insured and Medicaid products, largely offset by increases in Commercial ASC and Medicare products.

## Corporate/Other Segment

### *Commentary - 2018 compared to 2017*

#### *Revenues*

- Revenues in 2018 reflect (i) revenues associated with 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 and (ii) interest income related to the \$40 billion of senior notes issued on March 9, 2018 to partially fund the Aetna Acquisition.

### *Operating expenses*

- Operating expenses within the Corporate/Other segment include executive management, corporate relations, legal, compliance, human resources, information technology, finance related costs and acquisition-related transaction and integration costs. After the Aetna Acquisition Date, such operating expenses also include operating costs to support the large case pensions and long-term care insurance products acquired in the Aetna Acquisition.
- Operating expenses increased \$437 million, or 45.9%, in 2018 compared to 2017. The increase was primarily driven by an increase in acquisition-related transaction and integration costs of \$454 million in 2018.

### **Commentary - 2017 compared to 2016**

#### *Operating expenses*

- Operating expenses within the Corporate/Other segment include executive management, corporate relations, legal, compliance, human resources, information technology, finance related costs and acquisition-related transaction and integration costs.
- Operating expenses increased \$34 million, or 3.7%, in 2017 compared to 2016. The increase was due to (i) ongoing investments in strategic initiatives, (ii) increased employee benefit costs and (iii) increased divestiture and acquisition-related costs, primarily related to \$34 million of transaction costs in 2017 associated with the Aetna Acquisition.

## **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.

The net change in cash, cash equivalents and restricted cash for the years ended December 31, 2018, 2017 and 2016 is as follows:

<i><u>In millions</u></i>	<u>Year Ended December 31,</u>			<u>Change</u>			
				<u>2018 vs. 2017</u>		<u>2017 vs. 2016</u>	
	<u>2018</u>	<u>2017</u>	<u>2016</u>	<u>\$</u>	<u>%</u>	<u>\$</u>	<u>%</u>
Net cash provided by operating activities	\$ 8,865	\$ 8,007	\$ 10,141	\$ 858	11 %	\$ (2,134)	(21)%
Net cash used in investing activities	(43,285)	(2,877)	(2,470)	(40,408)	1,405 %	(407)	16 %
Net cash provided by (used in) financing activities	36,819	(6,751)	(6,761)	43,570	(645)%	10	— %
Effect of exchange rate changes on cash, cash equivalents and restricted cash	(4)	1	2	(5)	(500)%	(1)	(50)%
Net increase (decrease) in cash, cash equivalents and restricted cash	<u>\$ 2,395</u>	<u>\$ (1,620)</u>	<u>\$ 912</u>	<u>\$ 4,015</u>	<u>(248)%</u>	<u>\$ (2,532)</u>	<u>(278)%</u>

### Commentary - 2018 compared to 2017

- *Net cash provided by operating activities* increased by \$858 million in 2018 due primarily to the timing of client payments and the timing of payments for the Company's Medicare Part D operations.
- *Net cash used in investing activities* increased by \$40.4 billion in 2018 largely driven by the Aetna Acquisition in November 2018. In addition, cash used in investing activities reflected the following activity:
  - Gross capital expenditures remained relatively consistent at approximately \$2.0 billion and \$1.9 billion in 2018 and 2017, respectively. During 2018, approximately 21% of the Company's total capital expenditures were for new store construction, 32% were for store, fulfillment and support facilities expansion and improvements and 47% were for technology and other corporate initiatives.
  - The Company did not complete any sale-leaseback transactions in 2018 compared to \$265 million in 2017. Under the sale-leaseback transactions, the properties generally are sold at net book value, which generally approximates fair value, and the resulting leases generally qualify and are accounted for as operating leases. The specific timing and amount of future sale-leaseback transactions will vary depending on future market conditions and other factors.
- *Net cash provided by financing activities* was \$36.8 billion in 2018 compared to net cash used in financing activities of \$6.8 billion in 2017. The cash provided by financing activities in 2018 primarily related to long-term borrowings to partially fund the Aetna Acquisition.

### Commentary - 2017 compared to 2016

- *Net cash provided by operating activities* decreased by \$2.1 billion, in 2017 due primarily to the timing of payments for the Company's Medicare Part D operations.
- *Net cash used in investing activities* increased by \$407 million in 2017 largely driven by an increase in acquisition activity as compared to 2016. In addition, cash used in investing activities reflected the following activity:
  - Gross capital expenditures in 2017 totaled approximately \$1.9 billion, a decrease of \$306 million compared to prior year. The decrease in 2017 capital expenditures is due to the Target integration being completed in 2016. During 2017, approximately 25% of the Company's total capital expenditures were for new store construction, 30% were for store, fulfillment and support facilities expansion and improvements and 45% were for technology and other corporate initiatives.
  - Proceeds from sale-leaseback transactions totaled \$265 million in 2017 compared to \$230 million in 2016.
- *Net cash used in financing activities* was \$6.8 billion in both 2017 and 2016 as net borrowings and net payments to shareholders were relatively flat in both years.

Included in net cash used in investing activities for the years ended December 31, 2018, 2017 and 2016 was the following store development activity <sup>(1)</sup>:

	2018	2017	2016
Total stores (beginning of year)	9,846	9,750	9,665
New and acquired stores <sup>(2)</sup>	148	179	132
Closed stores <sup>(2)</sup>	(27)	(83)	(47)
Total stores (end of year)	9,967	9,846	9,750
Relocated stores <sup>(2)</sup>	34	30	50

(1) Includes retail drugstores, certain onsite pharmacy stores, retail specialty pharmacy stores and pharmacies within Target stores.

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

### Short-term Borrowings

#### Commercial Paper and Back-up Credit Facilities

The Company had approximately \$720 million and \$1.3 billion of commercial paper outstanding at weighted average interest rates of 2.8% and 2.0% as of December 31, 2018 and 2017, respectively. In connection with its commercial paper program, the Company maintains a \$1.75 billion 364-day unsecured back-up revolving credit facility, which expires on May 16, 2019, a \$1.25 billion, five-year unsecured back-up revolving credit facility, which expires on July 1, 2020, a \$1.0 billion, five-year

unsecured back-up revolving credit facility, which expires on May 18, 2022, and a \$2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 17, 2023. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately .03%, regardless of usage. As of December 31, 2018 and 2017, there were no borrowings outstanding under any of the back-up credit facilities.

#### *Bridge Loan Facility*

On December 3, 2017, in connection with the Aetna Acquisition, the Company entered into a \$49.0 billion unsecured bridge loan facility commitment. The Company paid \$221 million in fees upon entering into the agreement. The fees were capitalized in other current assets and were amortized as interest expense over the period the bridge loan facility commitment was outstanding. The bridge loan facility commitment was reduced to \$44.0 billion on December 15, 2017 upon the Company entering into a \$5.0 billion term loan agreement. The Company recorded \$56 million of amortization of the bridge loan facility fees during the year ended December 31, 2017, which was recorded in interest expense in the consolidated statements of operations.

On March 9, 2018, the Company issued unsecured senior notes with an aggregate principal amount of \$40.0 billion (see "Long-term Borrowings - 2018 Notes" below). At this time, the bridge loan facility commitment was reduced to \$4.0 billion, and the Company paid \$8 million in fees to retain the bridge loan facility commitment through the Aetna Acquisition Date. Those fees were capitalized in other current assets and were amortized as interest expense over the period the bridge loan facility commitment was outstanding. The Company recorded \$173 million of amortization of the bridge loan facility commitment fees during the year ended December 31, 2018, which was recorded in interest expense in the consolidated statement of operations. On October 26, 2018, the Company entered into a \$4.0 billion unsecured 364-day bridge term loan agreement to formalize the bridge loan facility discussed above. On November 28, 2018, in connection with the Aetna Acquisition, the \$4.0 billion unsecured 364-day bridge term loan agreement terminated.

#### *Federal Home Loan Bank of Boston*

Since the Aetna Acquisition Date, a subsidiary of the Company is a member of the Federal Home Loan Bank of Boston (the "FHLBB"). As a member, the subsidiary has the ability to obtain cash advances, subject to certain minimum collateral requirements. The maximum borrowing capacity available from the FHLBB as of December 31, 2018 was approximately \$790 million. As of December 31, 2018, there were no outstanding advances from the FHLBB.

### ***Long-term Borrowings***

#### *2018 Notes*

On March 9, 2018, the Company issued an aggregate of \$40.0 billion in principal amount of the 2018 Notes for total proceeds of approximately \$39.4 billion, net of discounts and underwriting fees. The net proceeds of the 2018 Notes were used to fund a portion of the Aetna Acquisition. The 2018 Notes are comprised of the following:

#### **In millions**

3.125% senior notes due March 2020	\$ 2,000
Floating rate notes due March 2020	1,000
3.35% senior notes due March 2021	3,000
Floating rate notes due March 2021	1,000
3.7% senior notes due March 2023	6,000
4.1% senior notes due March 2025	5,000
4.3% senior notes due March 2028	9,000
4.78% senior notes due March 2038	5,000
5.05% senior notes due March 2048	8,000
Total debt principal	<u>\$ 40,000</u>

#### *Term Loan Agreement*

On December 15, 2017, in connection with the Aetna Acquisition, the Company entered into a \$5.0 billion term loan agreement. The term loan facility under the term loan agreement consists of a \$3.0 billion three-year tranche and a \$2.0 billion five-year tranche. The term loan agreement allows for borrowings at various rates that are dependent, in part, on the Company's debt ratings. In connection with the Aetna Acquisition, the Company borrowed \$5.0 billion (a \$3.0 billion three-year tranche

and a \$2.0 billion five-year tranche) under the term loan agreement in November 2018. The Company terminated the \$2.0 billion five-year tranche in December 2018 with the repayment of the borrowing. As of December 31, 2018, the Company had \$3.0 billion outstanding under the three-year tranche of the term loan agreement.

#### *Aetna Related Debt*

Upon the closing of the Aetna Acquisition, the Company assumed long-term debt with a fair value of \$8.1 billion with stated interest rates ranging from 2.2% to 6.75%.

#### *2016 Notes*

On May 16, 2016, the Company issued \$1.75 billion aggregate principal amount of 2.125% unsecured senior notes due June 1, 2021 and \$1.75 billion aggregate principal amount of 2.875% unsecured senior notes due June 1, 2026 (collectively, the “2016 Notes”) for total proceeds of approximately \$3.5 billion, net of discounts and underwriting fees. The 2016 Notes may be redeemed, in whole at any time, or in part from time to time, at the Company’s option at a defined redemption price plus accrued and unpaid interest to the redemption date. The net proceeds of the 2016 Notes were used for general corporate purposes and to repay certain corporate debt.

#### *Early Extinguishment of Long-Term Debt*

On May 16, 2016, the Company announced tender offers for (i) any and all of its 5.75% senior notes due 2017, its 6.60% senior notes due 2019 and its 4.75% senior notes due 2020 (collectively, the “Any and All Notes”) and (ii) up to \$1.5 billion aggregate principal amount of the 4.75% Senior Notes due 2022 issued by its wholly-owned subsidiary Omnicare, the 5.00% Senior Notes due 2024 issued by Omnicare, its 3.875% Senior Notes due 2025, its 6.25% Senior Notes due 2027, its 4.875% Senior Notes due 2035, its 6.125% Senior Notes due 2039 and its 5.75% Senior Notes due 2041 (collectively, the “Maximum Tender Offer Notes” and together with the Any and All Notes, the “Notes”). On May 31, 2016, the Company increased the aggregate principal amount of the tender offers for the Maximum Tender Offer Notes to \$2.25 billion. The Company purchased approximately \$835 million aggregate principal amount of the Any and All Notes and \$2.25 billion aggregate principal amount of the Maximum Tender Offer Notes pursuant to the tender offers, which expired on June 13, 2016. In connection with the purchase of the Notes, the Company paid a premium of \$486 million in excess of the debt principal, wrote off \$50 million of unamortized deferred financing costs and incurred \$6 million in fees, for a total loss on early extinguishment of long-term debt of \$542 million, which was recorded in income from continuing operations in the consolidated statement of operations for the year ended December 31, 2016.

On June 27, 2016, the Company notified the holders of the remaining Any and All Notes that the Company was exercising its option to redeem the outstanding Any and All Notes pursuant to the terms of the Any and All Notes and the Indenture dated as of August 15, 2006, between the Company and The Bank of New York Mellon Trust Company, N.A. Approximately \$1.1 billion aggregate principal amount of Any and All Notes was redeemed on July 27, 2016. In connection with that redemption, the Company paid a premium of \$97 million in excess of the debt principal and wrote off \$4 million of unamortized deferred financing costs, for a total loss on early extinguishment of long-term debt of \$101 million, which was recorded in income from continuing operations in the consolidated statement of operations for the year ended December 31, 2016.

See Note 8 “Borrowings and Credit Agreements” and Note 12 “Shareholders’ Equity” to the consolidated financial statements 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. As of December 31, 2018 and 2017, the Company had outstanding derivative financial instruments (see Note 1 “Significant Accounting Policies” to the consolidated financial statements).

#### *Debt Covenants*

The Company’s back-up revolving credit facilities, unsecured senior notes, unsecured floating rate notes and term loan agreement (see Note 8 “Borrowings and Credit Agreements” to the consolidated financial statements) 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 covenants do not materially affect the Company’s financial or operating flexibility. As of December 31, 2018, the Company was in compliance with all of its debt covenants.

## ***Debt Ratings***

As of December 31, 2018, the Company's long-term debt was rated "Baa2" by Moody's and "BBB" by Standard & Poor's ("S&P"), and its commercial paper program was rated "P-2" by Moody's and "A-2" by S&P. In December 2017, subsequent to the announcement of the proposed acquisition of Aetna, Moody's changed the outlook on the Company's long-term debt to "Under Review" from "Stable." Similarly, S&P placed the Company's long-term debt outlook on "Watch Negative" from "Stable." Upon the issuance of the 2018 Notes on March 9, 2018, S&P lowered its corporate credit rating on the Company's long-term debt to "BBB" from "BBB+" and changed the outlook from "Watch Negative" to "Stable." On November 27, 2018, S&P lowered its rating on the long-term debt of Aetna to "BBB" from "A." On November 28, 2018, upon the completion of the Aetna Acquisition, Moody's lowered its rating on CVS Health Corporation's long-term debt to "Baa2" from "Baa1." Additionally, Moody's changed the outlook on CVS Health Corporation's long-term debt to "Negative" from "Under Review" and changed the outlook on the long-term debt of Aetna to "Negative" from "Stable." In assessing the Company's credit strength, the Company believes that both Moody's and S&P considered, among other things, the Company's capital structure and financial policies as well as its consolidated balance sheet, its historical acquisition activity and other financial information. Although the Company currently believes its long-term debt ratings will remain investment grade, it cannot guarantee the future actions of Moody's and/or S&P. The Company's debt ratings have a direct impact on its future borrowing costs, access to capital markets and new store operating lease costs.

## ***Share Repurchase Programs***

During the year ended December 31, 2018, the Company did not repurchase any shares of common stock. See Note 12 "Shareholders' Equity" to the consolidated financial statements for additional information about share repurchases for the years ended December 31, 2017 and 2016.

## ***Quarterly Cash Dividend***

In December 2015, the Company's Board of Directors (the "Board") authorized a 21% increase in our quarterly common stock cash dividend to \$0.425 per share effective in 2016. This increase equated to an annual dividend rate of \$1.70 per share. In December 2016, the Board authorized an 18% increase in our quarterly common stock cash dividend to \$0.50 per share effective in 2017. This increase equated to an annual dividend rate of \$2.00 per share. During 2018, the Company maintained its quarterly dividend of \$0.50 per share and expects to maintain its quarterly dividend of \$0.50 per share throughout 2019.

## ***Off-Balance Sheet Arrangements***

In connection with executing operating leases, the Company provides a guarantee of the lease payments. The Company also finances a portion of its new store development through sale-leaseback transactions, which involve selling stores to unrelated parties and then leasing the stores back under leases that generally qualify and are accounted for as operating leases. The Company does not have any retained or contingent interests in the sold stores, and does not provide any guarantees, other than a guarantee of the lease payments, in connection with the transactions. In accordance with generally accepted accounting principles, the Company's operating leases are not reflected on the consolidated balance sheets.

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. When the subsidiaries were disposed of, 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 these obligations.

As of December 31, 2018, the Company guaranteed approximately 85 such store leases (excluding the lease guarantees related to Linens 'n Things), with the maximum remaining lease term extending through 2029. Management believes the ultimate disposition of any of the remaining lease guarantees will not have a material adverse effect on the Company's consolidated financial condition or future cash flows. Please see "Results of Operations - Summary of Consolidated Financial Results - Commentary - 2018 compared to 2017 - Loss from discontinued operations" previously in this document for further information regarding the Company's guarantee of certain Linens 'n Things' store lease obligations.

## Contractual Obligations

The following table summarizes certain estimated future obligations by period under the Company's various contractual obligations at December 31, 2018. 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, 2018 (for example, the timing and volume of future services provided under fee-for-service arrangements and future membership levels for capitated arrangements).

<i>In millions</i>	Payments Due by Period				
	Total	2019	2020 to 2021	2022 to 2023	Thereafter
Operating leases	\$ 27,980	\$ 2,690	\$ 4,943	\$ 4,343	\$ 16,004
Capital lease obligations	1,241	74	146	146	875
Contractual lease obligations with Target <sup>(1)</sup>	2,074	—	—	—	2,074
Lease obligations for discontinued operations	12	4	8	—	—
Long-term debt	72,903	1,242	16,150	12,699	42,812
Interest payments on long-term debt <sup>(2)</sup>	37,949	3,061	5,595	4,594	24,699
Other long-term liabilities on the consolidated balance sheet <sup>(3)</sup>					
Future policy benefits <sup>(4)</sup>	6,728	575	1,200	952	4,001
Unpaid claims <sup>(4)</sup>	2,742	816	644	413	869
Policyholders' funds <sup>(4)(5)</sup>	1,266	632	127	86	421
Other liabilities	1,705	455	911	100	239
Total	<u>\$ 154,600</u>	<u>\$ 9,549</u>	<u>\$ 29,724</u>	<u>\$ 23,333</u>	<u>\$ 91,994</u>

- (1) The Company leases pharmacy and clinic space from Target. See Note 6 "Leases" to the consolidated financial statements for additional information regarding the lease arrangements with Target. Amounts related to the operating and capital leases with Target are reflected within the operating leases and capital lease obligations above. Amounts due after the remaining estimated economic lives of the buildings are reflected herein assuming equivalent stores continue to operate through the term of the arrangements.
- (2) Interest payments on long-term debt are calculated using outstanding balances and interest rates in effect on December 31, 2018.
- (3) Payments of other long-term liabilities exclude Separate Accounts liabilities of approximately \$3.9 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.
- (4) Total payments of future policy benefits, unpaid claims and policyholders' funds include \$1.2 billion, \$2.7 billion and \$339 million, respectively, of reserves for contracts subject to reinsurance. The Company expects the assuming reinsurance carrier to fund these obligations and has reflected these amounts as reinsurance recoverable assets on the consolidated balance sheets.
- (5) Customer funds associated with group life and health contracts of approximately \$2.3 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 and equity securities supporting experience-rated products of \$10 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 shareholders 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, 2018, the maximum amount of dividends that may be paid by the Company's insurance and HMO subsidiaries without prior approval by regulatory authorities was approximately \$584 million in the aggregate.

The Company maintains capital levels in its operating subsidiaries at or above targeted and/or required capital levels and dividends amounts in excess of these levels to meet liquidity requirements, including the payment of interest on debt and shareholder 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.

As of December 31, 2018, the Company held investments of \$531 million 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” to the consolidated financial statements 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, 2018, 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, 2018, 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.

### **Quantitative and Qualitative Disclosures About Market Risk**

On November 28, 2018 the Company completed the Aetna Acquisition. As of December 31, 2018, the Company’s earnings and financial condition were exposed to interest rate risk, credit quality risk, market valuation risk, foreign currency risk and commodity risk. As of December 31, 2017, the Company had outstanding interest rate derivative instruments related to its long-term debt and believed that its exposure to interest rate risk (inherent in the Company’s debt securities portfolio) was not material. We refer you to Note 1 “Significant Accounting Policies” to the consolidated financial statements.

### ***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, 2018:

#### ***In millions***

Experience-rated products	\$ 1,063
Remaining products	17,191
<b>Total investments</b>	<b>\$ 18,254</b>

Investment risks associated with experience-rated products generally do not impact results of operations. 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 December 31, 2018, with approximately \$3.9 billion rated AAA at December 31, 2018. The debt securities that were rated below investment grade (that

is, having a credit quality rating below BBB-/Baa3) were \$1.1 billion at December 31, 2018 (of which 6% at December 31, 2018, supported experience-rated products).

At December 31, 2018, the Company held \$373 million of municipal debt securities that were guaranteed by third parties, representing 2% of total investments at December 31, 2018. These securities had an average credit quality rating of AA- at December 31, 2018 with the guarantee. These securities had an average credit quality rating of A- at December 31, 2018 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 December 31, 2018, approximately 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" to the consolidated financial statements, which is incorporated by reference herein, 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" to the consolidated financial statements, which is incorporated by reference herein.

The Company regularly reviews debt securities in its portfolio to determine whether a decline in fair value below the cost basis or carrying value is other-than-temporary. When a debt security is in an unrealized capital loss position, the Company monitors the duration and severity of the loss to determine if sufficient market recovery can occur within a reasonable period of time. If a decline in fair value is considered other-than-temporary, the cost basis or carrying value of the debt security is written down. The write down is then bifurcated into its credit and non-credit related components. The amount of the credit-related component is included in net income, and the amount of the non-credit related component is included in other comprehensive income/loss, unless the Company intends to sell the debt security or it is more likely than not that the Company will be required to sell the debt security prior to its anticipated recovery of the debt security's amortized cost basis. Accounting for other-than-temporary impairment ("OTTI") of debt securities is considered a critical accounting estimate. The information under the heading "Critical Accounting Policies - Other-Than-Temporary Impairment of Debt Securities" contained in "Management's Discussion and Analysis of Financial Condition and Results of Operations" in the Annual Report is incorporated by reference herein.

### ***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, results of operations and cash flows assuming the occurrence of certain reasonably possible changes in near-term market rates and prices. Interest rate changes (whether resulting from changes in treasury yields or credit spreads or other factors) represent the most material risk exposure category for the Company. The Company has estimated the impact on the fair value of market sensitive instruments based on the net present value of cash flows using a representative set of likely future interest rate scenarios. The assumptions used were as follows: an immediate increase of 100 basis points in interest rates (which the Company believes represents a moderately adverse scenario and is approximately equal to the historical annual volatility of interest rate movements for intermediate-term available-for-sale debt securities) and an immediate decrease of 15% in prices for domestic equity securities.

Assuming an immediate 100 basis point increase in interest rates and immediate decrease of 15% in the prices for domestic equity securities, the theoretical decline in the fair values of market sensitive instruments at December 31, 2018 is as follows:

- The fair value of long-term debt would decline by \$3.9 billion (\$4.9 billion pretax). Changes in the fair value of long-term debt do not impact financial condition or results of operations.
- The theoretical reduction in the fair value of investment securities partially offset by the theoretical reduction in the fair value of interest rate sensitive liabilities would result in a net decline in fair value of \$364 million (\$461 million pretax) related to continuing non-experience-rated products. Reductions in the fair value of investment securities would be reflected as an unrealized loss in equity, as the Company classifies these securities as available for sale. The Company does not record liabilities at fair value.

Based on overall exposure to interest rate risk and equity price risk, the Company believes that these changes in market rates and prices would not materially affect consolidated near-term financial condition, results of operations or cash flows as of December 31, 2018.

### ***Evaluation of Foreign Currency and Commodity Risk***

As of each of December 31, 2018 and 2017, the Company did not have any material foreign currency exchange rate or commodity derivative instruments in place and believes its exposure to foreign currency exchange rate risk and commodity price risk is not material.

### ***Evaluation of Operational Risks***

The Company also faces certain operational risks, including risks related to information security, including cybersecurity. The Company and its vendors have experienced a variety of cyber attacks, and the Company and its vendors expect to continue to experience cyber attacks going forward. Among other things, the Company has experienced automated attempts to gain access to public facing networks, brute force, SYN flood and distributed denial of service attacks, attempted malware infections, vulnerability scanning, ransomware attacks, spear-phishing campaigns, mass reconnaissance attempts, injection attempts, phishing, PHP injection and cross-site scripting. The Company also has seen an increase in attacks designed to obtain access to consumers' accounts using illegally obtained demographic information. The Company is dedicating and will continue to dedicate significant resources and incur significant expenses to maintain and update on an ongoing basis the systems and processes that are designed to mitigate the information security risks it faces and protect the security of its computer systems, software, networks and other technology assets against attempts by unauthorized parties to obtain access to confidential information, destroy data, disrupt or degrade service, sabotage systems or cause other damage. The impact of the cyber attacks the Company has experienced through December 31, 2018 has not been material to its operations or results of operations. The Board and the Audit Committee of the Board ("the Audit Committee") are regularly informed regarding the Company's information security policies, practices and status.

### **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, 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" to the consolidated financial statements. 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, 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 Pharmacy Services segment, net of any discounts earned on brand name drugs or other discounts and refunds paid back to the client, (ii) the United States Centers for Medicare & Medicaid Services ("CMS") subsidized portion of prescription drugs dispensed to the Company's SilverScript PDP members, (iii) the price paid to the Pharmacy Services segment 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 (iv) claims based administrative fees for retail pharmacy network contracts. Sales taxes are not included in revenue.

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 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.

The Company recognizes revenue using the net method for contracts under which the Company acts as an agent or does not control the prescription drug prior to transfer to the client.

The Company records revenue net of manufacturers' rebates that are 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 as 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 results of operations or financial condition.

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 performance refund amounts has not been material to the Company's results of operations or financial condition.

The Pharmacy Services segment participates in the federal government's Medicare Part D program as a PDP through the Company's SilverScript subsidiary. Revenues include insurance premiums earned by the PDP, 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.

In addition to these premiums, the Pharmacy Services segment 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.

The Company estimates variable consideration in the form of amounts payable to, or receivable from, CMS under a risk-sharing feature of the Medicare Part D program design, referred to as 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.

#### *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 the third party payer for 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 have not been material to the Company's results of operations 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 results of operations or financial condition. Sales taxes are not included in revenue.

##### Loyalty Program

The Company's customer loyalty program, ExtraCare<sup>®</sup>, is comprised of two components, ExtraSavings<sup>™</sup> and ExtraBucks<sup>®</sup> 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 rewards are reflected as a contract liability.

##### 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 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 the revenue from sales of pharmaceutical and medical products are 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 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 results of operations.

Additionally, premium revenue subject to the ACA's minimum medical loss ratio ("MLR") rebate requirements is recorded net of the estimated minimum MLR rebates for the current calendar year. The Company estimates minimum MLR rebates payable by projecting MLRs for certain markets, as defined by the ACA, for each state in which each of its insurance entities operates. The claims and premiums used in estimating such rebates are modified for certain adjustments allowed by the ACA and include a statistical credibility adjustment for those states with a number of members that is not statistically credible.

Furthermore, the ACA's permanent risk adjustment program transfers 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, the Company estimates its ultimate risk adjustment receivable or payable for the current calendar year and reflects the pro-rata year-to-date impact as an adjustment to premium revenue. In this analysis, the Company considers the estimate of the average risk of members of other qualified plans in comparable markets the most critical assumption. The Company estimates its ultimate risk adjustment receivable or payable using management's best estimates, which are based on various data sources, including but not limited to market risk data compiled by third party sources as well as pricing and other regulatory inputs. See Note 1 "Significant Accounting Policies" to the consolidated financial statements for additional information on the ACA's risk adjustment program.

### *Other-Than-Temporary Impairments of Debt Securities*

The Company regularly reviews its debt securities to determine whether a decline in fair value below the cost basis or carrying value is other-than-temporary. If a decline in fair value is considered other-than-temporary, the cost basis or carrying value of the debt security is written down. The write-down is then bifurcated into its credit and non-credit related components. The amount of the credit-related component is included in results of operations, and the amount of the non-credit related component is included in other comprehensive income, unless the Company intends to sell the debt security or it is more likely than not that it will be required to sell the debt security prior to its anticipated recovery of its amortized cost basis. The Company analyzes all facts and circumstances believed to be relevant for each investment when performing this analysis, in accordance with applicable accounting guidance.

Among the factors considered in evaluating whether a decline in fair value is other-than-temporary are whether the decline results from a change in the quality of the debt security itself, whether the decline results from a downward movement in the market as a whole, and the prospects for realizing the carrying value of the debt security based on the investment's current and short-term prospects for recovery. For unrealized losses determined to be the result of market conditions (for example, increasing interest rates and volatility due to conditions in the overall market) or industry-related events, the Company determines whether it intends to sell the debt security or if it is more likely than not that it will be required to sell the debt security before recovery of its amortized cost basis. If either case is true, the Company recognizes an OTTI, and the cost basis/carrying amount of the debt security is written down to fair value.

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

## ***Vendor Allowances and Purchase Discounts***

### ***Pharmacy Services Segment***

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

### ***Retail/LTC Segment***

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

There have not been any material changes in the way the Company accounts for vendor allowances and 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 store 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 accompanying consolidated financial statements are properly stated. The 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, but are not limited to, 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 \$328 million as of December 31, 2018. 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 \$33 million as of December 31, 2018.

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.

## ***Goodwill and Identifiable Intangible Assets***

### *Identifiable intangible assets*

Identifiable intangible assets consist primarily of trademarks, trade names, customer contracts/relationships, covenants not to compete, technology, provider networks, value of business acquired and favorable leases. 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.

### *Recoverability of definite-lived intangible assets*

The Company evaluates the recoverability of definite-lived intangible assets whenever events or changes in circumstances indicate that the carrying value of an asset may not be recoverable. These long-lived assets are grouped and evaluated for impairment at the lowest level at which individual cash flows can be identified. When evaluating these long-lived assets for potential impairment, the Company first compares the carrying amount of the asset group to the asset group's estimated future cash flows (undiscounted and without interest charges). If the estimated future cash flows are less than that 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, but not limited to, 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 losses for definite-lived intangible assets recognized in any of the three years ended December 31, 2018, 2017 or 2016.

### *Recoverability of indefinitely-lived intangible assets*

Indefinitely-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. Indefinitely-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 indefinitely-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, but not limited to, general economic conditions, availability of market information as well as the profitability of the Company.

There were no material impairment losses recognized on indefinitely-lived intangible assets recognized in any of the three years ended December 31, 2018, 2017 or 2016.

### *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 calculated 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, but are not limited to, 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, 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. These estimates can be affected by a number of factors including, but not limited to, general economic and regulatory conditions, market capitalization, efforts of customers and payers to reduce costs including their prescription drug costs and/or increase member co-payments, the continued efforts of competitors to gain market share and consumer spending patterns.

#### *2018 goodwill impairment tests*

As discussed in Note 5 "Goodwill and Other Intangibles" to the consolidated financial statements, during 2018, the LTC reporting unit continued 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 and when the 2017 annual goodwill impairment test was performed. These challenges include lower client retention rates, lower occupancy rates in skilled nursing facilities, the deteriorating financial health of numerous skilled nursing facility customers which resulted in a number of customer bankruptcies in 2018, and continued facility reimbursement pressures. In June 2018, LTC management submitted its initial budget for 2019 and updated the 2018 annual forecast which showed a projected deterioration in the financial results for the remainder of 2018 and in 2019, which also caused management to update its long-term forecast beyond 2019. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be impaired and, accordingly, management performed an interim goodwill impairment test as of June 30, 2018. The results of that interim impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in a \$3.9 billion pre-tax goodwill impairment charge in the second quarter of 2018. The fair value of the LTC reporting unit was determined using a combination of a discounted cash flow method and a market multiple method. In addition to the lower financial projections, higher risk-free interest rates and lower market multiples of peer group companies contributed to the amount of the second quarter 2018 goodwill impairment charge.

During the third quarter of 2018, the Company performed its required annual impairment tests of goodwill. The results of these impairment tests indicated that there was no impairment of goodwill. The results of the annual goodwill impairment tests showed the fair values of the Pharmacy Services and Retail Pharmacy reporting units exceeded their carrying values by significant margins and the fair value of the LTC reporting unit exceeded its carrying value by approximately 2%.

During the fourth quarter of 2018, the LTC reporting unit missed its forecast primarily due to operational issues and customer liquidity issues, including one significant customer bankruptcy. Additionally, LTC management submitted an updated final budget for 2019 which showed significant additional deterioration in the projected financial results for 2019 compared to the analyses performed in the second and third quarters of 2018 primarily due to continued industry and operational challenges, which also caused management to make further updates to its long-term forecast beyond 2019. The updated projections continue to reflect industry wide challenges including lower occupancy rates in skilled nursing facilities, the 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 impaired and, accordingly, an interim goodwill impairment test was performed during the fourth quarter of 2018. The results of that 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 goodwill impairment charge in the fourth quarter of 2018. In addition to the lower financial projections, lower market multiples of peer group companies also contributed to the amount of the fourth quarter 2018 goodwill impairment charge. The fair value of the LTC reporting unit was determined using a methodology consistent with the methodology described above for the analyses performed during the second and third quarters of 2018.

As of December 31, 2018, the remaining goodwill balance in the LTC reporting unit is approximately \$431 million.

Although the Company believes the financial projections used to determine the fair value of the LTC reporting unit in the fourth quarter of 2018 are reasonable and achievable, the LTC reporting unit may continue to face challenges that may affect the Company's ability to grow its business at the rate estimated when such goodwill impairment test was performed. These challenges and some of the key assumptions included in the Company's financial projections to determine the estimated fair value of the LTC reporting unit include client retention rates, occupancy rates in skilled nursing facilities, the financial health of skilled nursing facility customers, facility reimbursement pressures, the Company's ability to execute its senior living initiative, the Company's ability to make acquisitions and integrate those businesses into its LTC operations in an orderly manner, as well as the Company's ability to extract cost savings from labor productivity and other initiatives. The Company has made a number of additions and changes to its LTC management team to better respond to these challenges. The estimated fair value of the LTC reporting unit also is dependent on earnings multiples of market participants in the pharmacy industry, as well as the risk-free interest rate environment, which impacts the discount rate used in the discounted cash flow valuation method. If the Company

does not achieve its forecasts, it is reasonably possible in the near term that the goodwill of the LTC reporting unit could be deemed to be impaired again by a material amount.

#### *2017 and 2016 goodwill impairment tests*

The Company recorded \$181 million in goodwill impairment charges in 2017 related to the RxCrossroads reporting unit. During the third quarter of 2017, the Company performed its required annual impairment test of goodwill. The goodwill impairment 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 values of the LTC and RxCrossroads reporting units exceeded their carrying values by approximately 1% and 6%, respectively. On January 2, 2018, the Company sold its RxCrossroads reporting unit to McKesson Corporation for \$725 million.

The Company did not record any goodwill impairment charges during 2016.

#### ***Health Care Costs Payable***

At December 31, 2018, 80% of health care costs payable are estimates of the ultimate cost of (i) services rendered to 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" to the consolidated financial statements for additional information on the Company's reserving methodology.

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, 2018. 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 16 basis points from the Company's assumed rates, which could impact health care costs payable by approximately plus or minus \$194 million pretax.

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, 2018, the Company increased its assumed health care cost trend rates for the most recent three months by 3.5% from health care cost trend rates recently observed. However, based on historical claim experience, it is reasonably possible that the Company's estimated health care cost trend rates may vary by plus or minus 3.5% from the assumed rates, which could impact health care costs payable by plus or minus \$299 million pretax.

#### ***Income Taxes***

Income taxes are accounted for 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. 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.

### ***Business Combinations***

The Company accounts for business combinations using the acquisition method of accounting which requires that the assets acquired and liabilities assumed be recorded at the date of the acquisition at their respective fair values. The excess of purchase price over the fair value of assets acquired and liabilities assumed is recorded as goodwill. Determining the fair value of identifiable assets, particularly intangible assets, and liabilities acquired also requires management to make estimates, which are based on all available information and in some cases assumptions with respect to the timing and amount of future revenues and expenses associated with an asset. The most critical assumptions used in determining the fair value of intangible assets include customer attrition, membership growth and revenue growth. In determining the estimated fair value for intangible assets, the Company typically utilizes the income approach, which discounts the projected future net cash flow using an appropriate discount rate that reflects the risks associated with such projected future cash flows. Determining the useful life of an intangible asset also requires judgment, as different types of intangible assets will have different useful lives and certain assets are considered to have indefinite useful lives.

### ***New Accounting Pronouncements***

See Note 1 “Significant Accounting Policies” to the consolidated financial statements for a description of new accounting pronouncements applicable to the Company.

### **Holders of Common Stock**

As of February 19, 2019, there were 27,266 registered holders of the Company’s common stock according to the records maintained by the Company’s transfer agent.

### **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 made by or on behalf of the Company. In addition, the Company and its representatives may, from time to time, make written or verbal forward-looking statements, including statements contained in the Company’s filings with the United States Securities and Exchange Commission (the “SEC”) and in its reports to stockholders, press releases, webcasts, conference calls, meetings and other communications. Generally, the inclusion of the words “anticipate,” “believe,” “estimate,” “expect,” “intend,” “project,” “should,” “will” and similar expressions identify statements that constitute forward-looking statements. All statements addressing operating performance of CVS Health Corporation or any subsidiary, events or developments that the Company projects, expects or anticipates will occur in the future, including statements relating to corporate strategy; revenue growth; adjusted revenue growth, earnings or earnings per common share growth; adjusted operating income or adjusted earnings per common share growth; free cash flow; debt ratings; inventory levels; inventory turn and loss rates; store development; relocations and new market entries; retail pharmacy business, sales results and/or trends and operations; PBM business, sales results and/or trends and operations; specialty pharmacy business, sales trends and operations; LTC pharmacy business, sales results and/or trends and operations; Health Care Benefits business, sales results and/or trends, medical cost trends, medical membership growth, medical benefit ratios and operations; the Company’s ability to attract or retain customers and clients; Medicare Part D competitive bidding, enrollment and operations; new product development; and the impact of industry and regulatory developments, as well as statements expressing optimism or pessimism about future results of operations or events, are forward-looking statements within the meaning of the Reform Act.

The forward-looking statements are and will be based upon management’s then-current views and assumptions regarding future events and operating performance, and are applicable only as of the dates of such statements. The Company undertakes no obligation to update or revise any forward-looking statements, whether as a result of new information, future events, or otherwise.

By their nature, all forward-looking statements involve risks and uncertainties. Actual results may differ materially from those contemplated by the forward-looking statements for a number of reasons as described in the Company's SEC filings, including those set forth in the Risk Factors section within the CVS Health Corporation's 2018 Annual Report on Form 10-K, and including, but not limited to:

- *Risks to our brand and reputation, the Aetna Acquisition, data governance risks, effectiveness of our talent management and alignment of talent to our business needs, and potential changes in public policy, laws and regulations present overarching risks to our enterprise in 2019 and beyond.*
- *Our brand and reputation are two of our most important assets; negative public perception of the industries in which we operate, or of our industries' or our practices, can adversely affect our businesses, results of operations, cash flows and prospects.*
- *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.*
- *We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success, and our failure to do so could adversely affect our future performance.*
- *We are subject to potential changes in public policy, laws and regulations, including reform of the United States health care system, that can adversely affect the markets for our products and services and our businesses, operations, results of operations, cash flows and prospects.*
- *Our enterprise strategy may not be an effective response to the changing dynamics in the industries in which we operate, or we may not be able to implement our strategy and related strategic projects.*
- *Efforts to reduce reimbursement levels and alter health care financing practices could adversely affect our businesses.*
- *Gross margins in the industries in which we operate may decline.*
- *Our results of operations are affected by the health of the economy in general and in the geographies we serve.*
- *We operate in a highly competitive business environment. Competitive and economic pressures may limit our ability to increase pricing to reflect higher costs or may force us to accept lower margins. If customers elect to self-insure, reduce benefits or adversely renegotiate or amend their agreements with us, our revenues and results of operations will be adversely affected. We may not be able to obtain appropriate pricing on new or renewal business.*
- *We may lose clients and/or fail to win new business. If we fail to compete effectively in the geographies and product areas in which we operate, including maintaining or increasing membership in our Health Care Benefits segment, our results of operations, financial condition and cash flows could be materially and adversely affected.*
- *We are exposed to risks relating to the solvency of our customers and of other insurers.*
- *We face risks relating to the market availability, pricing, suppliers and safety profiles of prescription drugs that we purchase and sell.*
- *We face risks related to the frequency and rate of the introduction and pricing of generic drugs and brand name prescription drug products.*
- *Possible changes in industry pricing benchmarks and drug pricing generally can adversely affect our PBM business.*
- *Product liability, product recall or personal injury issues could damage our reputation.*
- *We face challenges in growing our Medicare Advantage and Medicare Part D membership.*
- *We face challenges in growing our Medicaid membership, and expanding our Medicaid membership exposes us to additional risks.*
- *A change in our Health Care Benefits product mix may adversely affect our profit margins.*
- *We may not be able to accurately forecast health care and other benefit costs, which could adversely affect our Health Care Benefits segment's results of operations. There can be no assurance that the future health care and other benefit costs of our Insured Health Care Benefits products will not exceed our projections.*
- *A number of factors, many of which are beyond our control, contribute to rising health care and other benefit costs. If we are unable to satisfactorily manage our health care and other benefit costs, our Health Care Benefits segment's results of operations and competitiveness will be adversely affected.*
- *The reserves we hold for expected claims in our Insured Health Care Benefits products are based on estimates that involve an extensive degree of judgment and are inherently variable. Any reserve, including a premium deficiency reserve, may be insufficient. If actual claims exceed our estimates, our results of operations could be materially adversely affected, and our ability to take timely corrective actions to limit future costs may be limited.*
- *Extreme events, or the threat of extreme events, could materially increase our health care (including behavioral health) costs. We cannot predict whether or when any such events will occur.*
- *Legislative and regulatory changes could create significant challenges to our Medicare Advantage and Medicare Part D revenues and results of operations, and proposed changes to these programs could create significant additional challenges.*

*Entitlement program reform, if it occurs, could have a material adverse effect on our businesses, operations and/or results of operations.*

- We may not be able to obtain adequate premium rate increases in our Insured Health Care Benefits products, which would have an adverse effect on our revenues, MBRs and results of operations and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes.*
- Minimum MLR rebate requirements limit the level of margin we can earn in our Insured Health Care Benefits products while leaving us exposed to higher than expected medical costs. Challenges to our minimum MLR rebate methodology and/or reports could adversely affect our results of operations.*
- Our business activities are highly regulated. Our Pharmacy Services, Medicare Advantage, Medicare Part D, Medicaid, dual eligible, dual eligible special needs plan, small group and certain other products are subject to particularly extensive and complex regulations. If we fail to comply with applicable laws and regulations, we could be subject to significant adverse regulatory actions or suffer brand and reputational harm which may have a material adverse effect on our businesses. Compliance with existing and future laws, regulations and/or judicial decisions may reduce our profitability and limit our growth.*
- If our compliance or other systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions or litigation which could adversely affect our businesses, results of operations, cash flows and/or financial condition.*
- Our litigation and regulatory risk profile are changing as a result of the Aetna Acquisition and as we offer new products and services and expand in business areas beyond our historical core businesses of Retail/LTC and Pharmacy Services.*
- We routinely are subject to litigation and other adverse legal proceedings, including class actions and qui tam actions. Many of these proceedings seek substantial damages which may not be covered by insurance. These proceedings may be costly to defend, result in changes in our business practices, harm our brand and reputation and adversely affect our businesses and results of operations.*
- 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.*
- We are subject to retroactive adjustments to and/or withholding of certain premiums and fees, including as a result of CMS RADV audits. We generally rely on health care providers to appropriately code claim submissions and document their medical records. If these records do not appropriately support our risk adjusted premiums, we may be required to refund premium payments to CMS and/or pay fines and penalties under the False Claims Act.*
- Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues. The U.S. federal government and our other government customers may reduce funding for health care or other programs, cancel or decline to renew contracts with us, or make changes that adversely affect the number of persons eligible for certain programs, the services provided to enrollees in such programs, our premiums and our administrative and health care and other benefit costs, any of which could have a material adverse effect on our businesses, results of operations and cash flows. In addition, an extended federal government shutdown or a delay by Congress in raising the federal government's debt ceiling could lead to a delay, reduction, suspension or cancellation of federal government spending and a significant increase in interest rates that could, in turn, have a material adverse effect on our businesses, results of operations and cash flows.*
- Our results of operations may be adversely affected by changes in laws and policies governing employers and by union organizing activity.*
- We must develop and maintain a relevant omni-channel experience for our retail customers.*
- We must maintain and improve our relationships with our retail and specialty pharmacy customers and increase the demand for our products and services, including proprietary brands. If we fail to develop new products, differentiate our products from those of our competitors or demonstrate the value of our products to our customers and members, our ability to retain or grow our customer base may be adversely affected.*
- In order to be competitive in the increasingly consumer-oriented marketplace for our health care products and services, we will need to develop and deploy consumer-friendly products and services and make investments in consumer engagement, reduce our cost structure and compete successfully with new entrants into our businesses. If we are unsuccessful, our future growth and profitability may be adversely affected.*
- Our results of operations may be adversely affected if we are unable to contract with manufacturers, providers, suppliers and vendors on competitive terms and develop and maintain attractive networks with high quality providers.*
- If our service providers fail to meet their contractual obligations to us or to comply with applicable laws or regulations, we may be exposed to brand and reputational harm, litigation or regulatory action. This risk is particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs.*
- 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.*

- *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.*
- *Customers, particularly large sophisticated customers, expect us to implement their contracts and onboard their employees and members efficiently and effectively. Failure to do so could adversely affect our reputation, businesses, results of operations, cash flows and prospects. If we or our vendors fail to provide our customers with quality service that meets their expectations, our ability to retain and grow our membership and customer base will be adversely affected.*
- *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.*
- *Our and our vendors' operations are subject to a variety of business continuity hazards and risks, any of which could interrupt our operations or otherwise adversely affect our performance and results of operations.*
- *We and our vendors have experienced cyber attacks. We can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future.*
- *The failure or disruption of our information technology systems or the failure of our information technology infrastructure to support our businesses could adversely affect our reputation, businesses, results of operations and cash flows.*
- *Our business success and results of operations depend in part on effective information technology systems and on continuing to develop and implement improvements in technology. Pursuing multiple initiatives simultaneously could make this continued development and implementation significantly more challenging.*
- *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.*
- *We also face other risks that could adversely affect our businesses, results of operations, financial condition and/or cash flows, which include:*
  - *Failure of our corporate governance policies or procedures, for example significant financial decisions being made at an inappropriate level in our organization;*
  - *Inappropriate application of accounting principles or a significant failure of internal control over financial reporting, which could lead to a restatement of our results of operations and/or a deterioration in the soundness and accuracy of our reported results of operations; and*
  - *Failure to adequately manage our run-off businesses and/or our regulatory and financial exposure to businesses we have sold, including Aetna's divested standalone Medicare Part D, domestic group life insurance, group disability insurance and absence management businesses.*
- *Goodwill and other intangible assets could, in the future, become impaired.*
- *We would be adversely affected if we do not effectively deploy our capital. Downgrades or potential downgrades in our credit ratings, should they occur, could adversely affect our brand and reputation, businesses, cash flows, financial condition and results of operations.*
- *Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative investments and other investments, our results of operations and/or our financial condition.*
- *We have limited experience in the insurance and managed health care industry, which may hinder our ability to achieve our objectives as a combined company.*
- *The Aetna Acquisition may not be accretive, and may be dilutive, to our earnings per share, which may adversely affect our stock price.*
- *We may fail to successfully combine the businesses and operations of CVS Health and Aetna to realize the anticipated benefits and cost savings of the Aetna Acquisition within the anticipated timeframe or at all, which could adversely affect our stock price.*
- *Our future results may be adversely impacted if we do not effectively manage our expanded operations following completion of the Aetna Acquisition.*
- *We may have difficulty attracting, motivating and retaining executives and other key employees following completion of the Aetna Acquisition.*
- *The Aetna integration process could disrupt our ongoing businesses and/or operations.*
- *Our indebtedness following completion of the Aetna Acquisition is substantially greater than our indebtedness on a stand-alone basis and greater than the combined indebtedness of CVS Health and Aetna existing prior to the announcement of the transaction. This increased level of indebtedness could adversely affect our business flexibility and increase our borrowing costs.*
- *We will continue to incur significant integration-related costs in connection with the Aetna Acquisition.*

- *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 may be unable to successfully integrate companies we acquire.*
- *As a result of our expanded international operations, we face political, legal and compliance, operational, regulatory, economic and other risks that we do not face or are more significant than in our domestic operations.*

The foregoing list is not exhaustive. There can be no assurance that the Company has correctly 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. Should any risks or uncertainties develop into actual events, these developments could have a material adverse effect on the Company's businesses, results of operations, cash flows and/or financial condition. For these reasons, you are cautioned not to place undue reliance on the Company's forward-looking statements.

## 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, 2018.

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 the Company'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.

On November 28, 2018, the Company completed its acquisition of Aetna Inc. ("Aetna"). Management's assessment of the effectiveness of the Company's internal control over financial reporting as of December 31, 2018 excludes Aetna from that assessment as permitted under SEC rules. Aetna's operations are included in the Company's consolidated financial statements for the period from November 28, 2018 to December 31, 2018 and represented 21% of the Company's consolidated total assets as of December 31, 2018 and 3% of the Company's consolidated total revenues for the year ended December 31, 2018.

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, 2018.

Ernst & Young LLP, the Company's independent registered public accounting firm, is appointed by the Board of Directors and ratified by the Company's shareholders. 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 accompanying reports are based upon audits conducted in accordance with the standards of the Public Company Accounting Oversight Board (United States).

February 28, 2019

## **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, 2018, 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, 2018, based on the COSO criteria.

As indicated in the accompanying Management's Report on Internal Control Over Financial Reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of Aetna Inc., which is included in the 2018 consolidated financial statements of the Company and constituted 21% of total assets as of December 31, 2018 and 3% of revenues for the year then ended. Our audit of internal control over financial reporting of the Company also did not include an evaluation of the internal control over financial reporting of Aetna Inc.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of the Company as of December 31, 2018 and 2017, 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, 2018, and the related notes and our report dated February 28, 2019 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 28, 2019

## Consolidated Statements of Operations

<i><b>In millions, except per share amounts</b></i>	<b>For the Years Ended December 31,</b>		
	<b>2018</b>	<b>2017</b>	<b>2016</b>
<b>Revenues:</b>			
Products	\$ 183,910	\$ 180,063	\$ 173,377
Premiums	8,184	3,558	3,069
Services	1,825	1,144	1,080
Net investment income	660	21	20
<b>Total revenues</b>	<b>194,579</b>	<b>184,786</b>	<b>177,546</b>
<b>Operating costs:</b>			
Cost of products sold	156,447	153,448	146,533
Benefit costs	6,594	2,810	2,179
Goodwill impairments	6,149	181	—
Operating expenses	21,368	18,809	18,448
<b>Total operating costs</b>	<b>190,558</b>	<b>175,248</b>	<b>167,160</b>
<b>Operating income</b>	<b>4,021</b>	<b>9,538</b>	<b>10,386</b>
Interest expense	2,619	1,062	1,078
Loss on early extinguishment of debt	—	—	643
Other expense (income)	(4)	208	28
<b>Income before income tax provision</b>	<b>1,406</b>	<b>8,268</b>	<b>8,637</b>
Income tax provision	2,002	1,637	3,317
<b>Income (loss) from continuing operations</b>	<b>(596)</b>	<b>6,631</b>	<b>5,320</b>
Loss from discontinued operations, net of tax	—	(8)	(1)
<b>Net income (loss)</b>	<b>(596)</b>	<b>6,623</b>	<b>5,319</b>
Net (income) loss attributable to noncontrolling interests	2	(1)	(2)
<b>Net income (loss) attributable to CVS Health</b>	<b>\$ (594)</b>	<b>\$ 6,622</b>	<b>\$ 5,317</b>
<b>Basic earnings (loss) per share:</b>			
Income (loss) from continuing operations attributable to CVS Health	\$ (0.57)	\$ 6.48	\$ 4.93
Loss from discontinued operations attributable to CVS Health	\$ —	\$ (0.01)	\$ —
Net income (loss) attributable to CVS Health	\$ (0.57)	\$ 6.47	\$ 4.93
Weighted average basic shares outstanding	1,044	1,020	1,073
<b>Diluted earnings (loss) per share:</b>			
Income (loss) from continuing operations attributable to CVS Health	\$ (0.57)	\$ 6.45	\$ 4.91
Loss from discontinued operations attributable to CVS Health	\$ —	\$ (0.01)	\$ —
Net income (loss) attributable to CVS Health	\$ (0.57)	\$ 6.44	\$ 4.90
Weighted average diluted shares outstanding	1,044	1,024	1,079
Dividends declared per share	\$ 2.00	\$ 2.00	\$ 1.70

See accompanying notes to consolidated financial statements.

**Consolidated Statements of Comprehensive Income (Loss)**

<i><b>In millions</b></i>	<b>For the Years Ended December 31,</b>		
	<b>2018</b>	<b>2017</b>	<b>2016</b>
Net income (loss)	\$ (596)	\$ 6,623	\$ 5,319
Other comprehensive income (loss), net of tax:			
Net unrealized investment gains	97	—	—
Foreign currency translation adjustments	(29)	(2)	38
Net cash flow hedges	330	(10)	2
Pension and other postretirement benefits	(124)	152	13
Other comprehensive income	274	140	53
Comprehensive income (loss)	(322)	6,763	5,372
Comprehensive (income) loss attributable to noncontrolling interests	2	(1)	(2)
Comprehensive income (loss) attributable to CVS Health	\$ (320)	\$ 6,762	\$ 5,370

See accompanying notes to consolidated financial statements.

## Consolidated Balance Sheets

<i>In millions, except per share amounts</i>	At December 31,	
	2018	2017
<b>Assets:</b>		
Cash and cash equivalents	\$ 4,059	\$ 1,696
Investments	2,522	111
Accounts receivable, net	17,631	13,181
Inventories	16,450	15,296
Other current assets	4,581	945
<b>Total current assets</b>	<b>45,243</b>	<b>31,229</b>
Long-term investments	15,732	112
Property and equipment, net	11,349	10,292
Goodwill	78,678	38,451
Intangible assets, net	36,524	13,630
Separate accounts assets	3,884	—
Other assets	5,046	1,417
<b>Total assets</b>	<b>\$ 196,456</b>	<b>\$ 95,131</b>
<b>Liabilities:</b>		
Accounts payable	\$ 8,925	\$ 8,863
Pharmacy claims and discounts payable	12,302	10,355
Health care costs payable	5,210	5
Policyholders' funds	2,939	—
Accrued expenses	10,711	6,581
Other insurance liabilities	1,937	23
Short-term debt	720	1,276
Current portion of long-term debt	1,265	3,545
<b>Total current liabilities</b>	<b>44,009</b>	<b>30,648</b>
Long-term debt	71,444	22,181
Deferred income taxes	7,677	2,996
Separate accounts liabilities	3,884	—
Other long-term insurance liabilities	8,119	334
Other long-term liabilities	2,780	1,277
<b>Total liabilities</b>	<b>137,913</b>	<b>57,436</b>
Commitments and contingencies (Note 16)		
<b>Shareholders' equity:</b>		
CVS Health 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; 1,720 shares issued and 1,295 shares outstanding at December 31, 2018 and 1,712 shares issued and 1,014 shares outstanding at December 31, 2017 and capital surplus	45,440	32,096
Treasury stock, at cost: 425 shares at December 31, 2018 and 698 shares at December 31, 2017	(28,228)	(37,796)
Retained earnings	40,911	43,556
Accumulated other comprehensive income (loss)	102	(165)
<b>Total CVS Health shareholders' equity</b>	<b>58,225</b>	<b>37,691</b>
Noncontrolling interests	318	4
<b>Total shareholders' equity</b>	<b>58,543</b>	<b>37,695</b>
<b>Total liabilities and shareholders' equity</b>	<b>\$ 196,456</b>	<b>\$ 95,131</b>

See accompanying notes to consolidated financial statements.

## Consolidated Statements of Cash Flows

<i><u>In millions</u></i>	<b>For the Years Ended December 31,</b>		
	<b>2018</b>	<b>2017</b>	<b>2016</b>
<b>Cash flows from operating activities:</b>			
Cash receipts from customers	\$ 186,519	\$ 176,594	\$ 172,310
Cash paid for inventory and prescriptions dispensed by retail network pharmacies	(148,821)	(146,469)	(140,312)
Insurance benefits paid	(7,057)	(2,810)	(2,199)
Cash paid to other suppliers and employees	(17,234)	(15,348)	(15,478)
Interest and investment income received	644	21	20
Interest paid	(2,803)	(1,072)	(1,140)
Income taxes paid	(2,383)	(2,909)	(3,060)
<b>Net cash provided by operating activities</b>	<b>8,865</b>	<b>8,007</b>	<b>10,141</b>
<b>Cash flows from investing activities:</b>			
Proceeds from sales and maturities of investments	817	61	91
Purchases of investments	(692)	(137)	(80)
Purchases of property and equipment	(2,037)	(1,918)	(2,224)
Proceeds from sale-leaseback transactions	—	265	230
Acquisitions (net of cash acquired)	(42,226)	(1,181)	(524)
Proceeds from sale of subsidiary and other assets	832	—	—
Other	21	33	37
<b>Net cash used in investing activities</b>	<b>(43,285)</b>	<b>(2,877)</b>	<b>(2,470)</b>
<b>Cash flows from financing activities:</b>			
Net repayments of short-term debt	(556)	(598)	1,874
Proceeds from issuance of long-term debt	44,343	—	3,455
Repayments of long-term debt	(5,522)	—	(5,943)
Purchase of noncontrolling interest in subsidiary	—	—	(39)
Payment of contingent consideration	—	—	(26)
Derivative settlements	446	—	—
Repurchase of common stock	—	(4,361)	(4,461)
Dividends paid	(2,038)	(2,049)	(1,840)
Proceeds from exercise of stock options	242	329	296
Payments for taxes related to net share settlement of equity awards	(97)	(71)	(72)
Other	1	(1)	(5)
<b>Net cash provided by (used in) financing activities</b>	<b>36,819</b>	<b>(6,751)</b>	<b>(6,761)</b>
Effect of exchange rate changes on cash, cash equivalents and restricted cash	(4)	1	2
<b>Net increase (decrease) in cash, cash equivalents and restricted cash</b>	<b>2,395</b>	<b>(1,620)</b>	<b>912</b>
Cash, cash equivalents and restricted cash at the beginning of the period	1,900	3,520	2,608
<b>Cash, cash equivalents and restricted cash at the end of the period</b>	<b>\$ 4,295</b>	<b>\$ 1,900</b>	<b>\$ 3,520</b>

<i>In millions</i>	<b>For the Years Ended December 31,</b>		
	<b>2018</b>	<b>2017</b>	<b>2016</b>
<b>Reconciliation of net income (loss) to net cash provided by operating activities:</b>			
Net income (loss)	\$ (596)	\$ 6,623	\$ 5,319
<b>Adjustments required to reconcile net income (loss) to net cash provided by operating activities:</b>			
Depreciation and amortization	2,718	2,479	2,475
Goodwill impairments	6,149	181	—
Losses on settlements of defined benefit pension plans	—	187	—
Stock-based compensation	280	234	222
Loss on early extinguishment of debt	—	—	643
Deferred income taxes	87	(1,334)	18
Other noncash items	339	53	135
<b>Change in operating assets and liabilities, net of effects from acquisitions:</b>			
Accounts receivable, net	(1,139)	(941)	(243)
Inventories	(1,153)	(514)	(742)
Other assets	(3)	(338)	(8)
Accounts payable and pharmacy claims and discounts payable	2,489	1,710	2,189
Health care costs payable and other insurance liabilities	(471)	—	(19)
Other liabilities	165	(333)	152
Net cash provided by operating activities	<u>\$ 8,865</u>	<u>\$ 8,007</u>	<u>\$ 10,141</u>

See accompanying notes to consolidated financial statements.

## Consolidated Statements of Shareholders' Equity

<i>In millions</i>	Number of shares outstanding		Attributable to CVS Health						
	Common Shares	Treasury Shares <sup>(1)</sup>	Common Stock and Capital Surplus <sup>(2)</sup>	Treasury Stock <sup>(1)</sup>	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total CVS Health Shareholders' Equity	Non Controlling Interests	Total Equity
			\$	\$	\$	\$	\$	\$	\$
<b>Balance at December 31, 2015</b>	1,699	(598)	\$ 30,965	\$ (28,917)	\$ 35,506	\$ (358)	\$ 37,196	\$ 7	\$ 37,203
Net income <sup>(3)</sup>	—	—	—	—	5,317	—	5,317	1	5,318
Other comprehensive income (Note 13)	—	—	—	—	—	53	53	—	53
Stock option activity, stock awards, related tax benefits and other	6	—	525	—	—	—	525	—	525
Purchase of treasury shares, net of ESPP issuances	—	(46)	145	(4,566)	—	—	(4,421)	—	(4,421)
Common stock dividends	—	—	—	—	(1,840)	—	(1,840)	—	(1,840)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(4)	(4)
<b>Balance at December 31, 2016</b>	1,705	(644)	31,635	(33,483)	38,983	(305)	36,830	4	36,834
Net income	—	—	—	—	6,622	—	6,622	1	6,623
Other comprehensive income (Note 13)	—	—	—	—	—	140	140	—	140
Stock option activity, stock awards and other	7	—	461	—	—	—	461	—	461
Purchase of treasury shares, net of ESPP issuances	—	(54)	—	(4,313)	—	—	(4,313)	—	(4,313)
Common stock dividends	—	—	—	—	(2,049)	—	(2,049)	—	(2,049)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(1)	(1)
<b>Balance at December 31, 2017</b>	1,712	(698)	32,096	(37,796)	43,556	(165)	37,691	4	37,695
Adoption of new accounting standards (Note 1)	—	—	—	—	(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)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(13)	(13)
Acquisition of noncontrolling interests	—	—	—	—	—	—	—	329	329
<b>Balance at December 31, 2018</b>	<b>1,720</b>	<b>(425)</b>	<b>\$ 45,440</b>	<b>\$ (28,228)</b>	<b>\$ 40,911</b>	<b>\$ 102</b>	<b>\$ 58,225</b>	<b>\$ 318</b>	<b>\$ 58,543</b>

- (1) Treasury shares include 1 million shares held in trust for each of the years ended December 31, 2018, 2017 and 2016. Treasury stock includes \$29 million related to shares held in trust for the year ended December 31, 2018 and \$31 million related to shares held in trust for each of the years ended December 31, 2017 and 2016. 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, 2018, 2017 and 2016.
- (3) Net income attributable to noncontrolling interests for the year ended December 31, 2016 excludes \$1 million attributable to a redeemable noncontrolling interest. See Note 1 "Significant Accounting Policies" for additional information.

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,” the “Company,” “we,” “our” or “us”), is the nation’s premier health innovation company helping people on their path to better health. Whether in one of its pharmacies or through its health services and plans, CVS Health is pioneering a bold new approach to total health by making quality care more affordable, accessible, simple and seamless. CVS Health is community-based and locally focused, engaging consumers with the care they need when and where they need it. The Company has more than 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 92 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year, expanding specialty pharmacy services, and a leading stand-alone Medicare Part D prescription drug plan. CVS Health also serves an estimated 38 million people through traditional, voluntary and consumer-directed health insurance products and related services, including rapidly expanding Medicare Advantage offerings. The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

On November 28, 2018 (the “Aetna Acquisition Date”), the Company acquired Aetna Inc. (“Aetna”). As a result of the acquisition of Aetna (the “Aetna Acquisition”), the Company added the Health Care Benefits segment, which is the equivalent of the former Aetna Health Care segment. The Company now has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other, which are described below. The consolidated financial statements for the year ended December 31, 2018 reflect Aetna’s results subsequent to the Aetna Acquisition Date.

#### *Pharmacy Services Segment (“PSS”)*

PSS provides a full range of pharmacy benefit management (“PBM”) solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services, mail order pharmacy, specialty pharmacy and infusion services, Medicare Part D services, clinical services, disease management services and medical spend management. PSS’ clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D prescription drug plans (“PDPs”), Medicaid managed care plans, plans offered on public health insurance exchanges (“Public Exchanges”) and private health insurance exchanges, other sponsors of health benefit plans and individuals throughout the United States. In addition, the Company is a national provider of drug benefits to eligible beneficiaries under the Medicare Part D prescription drug program. PSS 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 (“RLS”)*

RLS sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products, cosmetics and personal care products, provides health care services through its MinuteClinic® walk-in medical clinics and conducts long-term care (“LTC”) pharmacy operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. Prior to January 2, 2018, RLS also provided commercialization services under the name RxCrossroads®. The Company divested its RxCrossroads subsidiary on January 2, 2018. As of December 31, 2018, RLS operated more than 9,900 retail locations, over 1,100 MinuteClinic® locations as well as online retail pharmacy websites, LTC pharmacies and onsite pharmacies.

#### *Health Care Benefits Segment (“HCBS”)*

HCBS is one of the nation’s leading diversified health care benefits providers, serving an estimated 38 million people as of December 31, 2018. HCBS has the information and resources to help members, in consultation with their health care professionals, make better informed decisions about their health care. HCBS offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services, workers’ compensation administrative services and health information technology products and services. HCBS’ 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 of medical and dental care costs) as “ASC.”

### *Corporate/Other Segment*

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

- Management and administrative expenses to support the overall operations of the Company, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments; and
- Products for which the Company no longer solicits or accepts new customers such as its large case pensions and long-term care insurance products.

### ***Basis of Presentation***

The accompanying consolidated financial statements of CVS Health Corporation 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***

As of December 31, 2018 and 2017, the Company had \$230 million and \$190 million, respectively, of restricted cash held in a trust in an insurance captive to satisfy collateral requirements associated with the assignment of certain insurance policies. Such amounts are included in other assets on the consolidated balance sheets. Additionally, as of December 31, 2018 and 2017, the Company had \$6 million and \$14 million, respectively, of restricted cash held in escrow accounts in connection with certain recent acquisitions. Such amounts are included in other current assets on the consolidated balance sheets.

### ***Investments***

#### ***Debt Securities***

Debt securities consist primarily of United States 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 within the consolidated balance sheets. Debt securities are classified as available for sale and are carried at fair value. See Note 4 “Fair Value” for additional information on how the Company estimates the fair value of these investments.

The cost for mortgage-backed and other asset-backed securities is adjusted for unamortized premiums and discounts, which are amortized using the interest method over the estimated remaining term of the securities, adjusted for anticipated prepayments.

Debt securities are regularly reviewed to determine whether a decline in fair value below the cost basis or carrying value is other-than-temporary. When a debt security is in an unrealized capital loss position, the Company monitors the duration and severity of the loss to determine if sufficient market recovery can occur within a reasonable period of time. If a decline in the

fair value of a debt security is considered other-than-temporary, the cost basis or carrying value of the debt security is written down. The write-down is then bifurcated into its credit and non-credit related components. The amount of the credit-related component is included in net income, and the amount of the non-credit related component is included in other comprehensive income/loss, unless the Company intends to sell the debt security or it is more likely than not that the Company will be required to sell the debt security prior to its anticipated recovery of the debt security's amortized cost basis. Interest is not accrued on debt securities when management believes the collection of interest is unlikely.

#### *Equity Securities*

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

#### *Mortgage Loans*

Mortgage loan investments on the consolidated balance sheets are valued at the unpaid principal balance, net of impairment reserves. A mortgage loan may be impaired when it is a problem loan (i.e., more than 60 days delinquent, in bankruptcy or in process of foreclosure), a potential problem loan (i.e., high probability of default) or a restructured loan. For impaired loans, a specific impairment reserve is established for the difference between the recorded investment in the loan and the estimated fair value of the collateral. The Company applies its loan impairment policy individually to all loans in its portfolio.

The impairment evaluation described above also considers characteristics and risk factors attributable to the aggregate portfolio. An additional allowance for loan losses is established if it is probable that there will be a credit loss on a group of similar mortgage loans. The following characteristics and risk factors are considered when evaluating if a credit loss is probable on a group of similar mortgage loans: loan-to-value ratios, property type (e.g., office, retail, apartment, industrial), geographic location, vacancy rates and property condition.

Full or partial impairments of loans are recorded at the time an event occurs affecting the legal status of the loan, typically at the time of foreclosure or upon a loan modification giving rise to forgiveness of debt. Interest income on a potential problem loan or restructured loan is accrued to the extent it is deemed to be collectible and the loan continues to perform under its original or restructured terms. Interest income on problem loans is recognized on a cash basis. Cash payments on loans in the process of foreclosure are treated as a return of principal. Mortgage loans with a maturity date or a committed prepayment date within twelve months are classified as current on the consolidated balance sheets.

#### *Other Investments*

Other investments consist primarily of the following:

- Private equity and hedge fund limited partnerships are accounted for using the equity method of accounting. Under this method, the carrying value of the investments are 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 net income in the consolidated results of operations (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 in the consolidated results of operations (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, which are reflected in policyholders' funds on the consolidated balance sheets.

### *Derivative Financial Instruments*

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

### *Accounts Receivable*

Accounts receivable are stated net of allowances for doubtful accounts, customer credit allowances, contractual allowances and estimated terminations. Accounts receivable, net consists of the following at December 31:

<i><u>In millions</u></i>	<b>2018</b>	<b>2017</b>
Trade receivables	\$ 6,896	\$ 7,895
Vendor and manufacturer receivables	7,655	5,109
Premium receivables	2,259	31
Other receivables	821	146
Total accounts receivable, net	<u>\$ 17,631</u>	<u>\$ 13,181</u>

The activity in the allowance for doubtful accounts receivable for the years ended December 31 is as follows:

<i><u>In millions</u></i>	<b>2018</b>	<b>2017</b>	<b>2016</b>
Beginning balance	\$ 307	\$ 286	\$ 161
Additions charged to bad debt expense	256	177	221
Write-offs charged to allowance	(70)	(156)	(96)
Ending balance	<u>\$ 493</u>	<u>\$ 307</u>	<u>\$ 286</u>

## ***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 accompanying 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 trends.

## ***Reinsurance Recoverables***

The Company utilizes reinsurance agreements primarily to reduce its required capital and to 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 results of operations 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, 2018, 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 and Pharmacy Services segments 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, 2018, the balance of deferred acquisition costs was \$22 million, 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 5 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:

<b><i>In millions</i></b>	<b>2018</b>	<b>2017</b>
Land	\$ 1,872	\$ 1,707
Building and improvements	3,785	3,343
Fixtures and equipment	13,028	11,963
Leashold improvements	5,384	4,793
Software	2,800	2,484
Total property and equipment	26,869	24,290
Accumulated depreciation and amortization	(15,520)	(13,998)
Property and equipment, net	<u>\$ 11,349</u>	<u>\$ 10,292</u>

The amount of property and equipment under capital leases at December 31 is as follows:

<i><b>In millions</b></i>	<b>2018</b>	<b>2017</b>
Property and equipment under capital leases	\$ 582	\$ 588
Accumulated amortization of property and equipment under capital leases	(163)	(140)
Property and equipment under capital leases, net	<u>\$ 419</u>	<u>\$ 448</u>

Depreciation expense (which includes the amortization of property and equipment under capital leases) totaled \$1.7 billion in each of the years ended December 31, 2018, 2017 and 2016.

### ***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. 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. See Note 5 “Goodwill and Other Intangibles” for additional information about goodwill and goodwill impairments.

### ***Intangible Assets***

The Company’s definite-lived intangible assets are amortized over their estimated useful-life based upon the pattern of future cash flows attributable to the asset. Other than value of business acquired (“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. The Company groups and evaluates definite-lived intangible assets for impairment at the lowest level at which individual cash flows can be identified whenever events or changes in circumstances indicate that the carrying value of 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 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 losses recognized on definite-lived intangible assets in any of the three years ended December 31, 2018, 2017 or 2016.

Indefinitely-lived intangible assets are not amortized but are tested for impairment annually, or more frequently if necessary. Indefinitely-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 indefinitely-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 indefinitely-lived intangible assets in any of the three years ended December 31, 2018, 2017 or 2016.

See Note 5 “Goodwill and Other Intangibles” for additional information about intangible assets.

### ***Separate Accounts***

Separate Accounts assets and liabilities related to large case pensions products represent funds maintained to meet specific objectives of contract holders who bear the investment risk. These assets and liabilities are carried at fair value. Net investment income (including net realized capital gains and losses) accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from the Company’s other businesses. Deposits, withdrawals and net investment income (including net realized and net unrealized capital gains and losses) on Separate Accounts assets are not reflected in the consolidated statements of operations or cash flows. Management fees charged to contract holders are included in services revenue and recognized over the period earned.

## ***Health Care Costs Payable***

Health care costs payable consist principally of unpaid fee-for-service medical, dental and pharmacy claims, capitation costs, other amounts due to health care providers pursuant to risk-sharing arrangements primarily 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 consolidated results of operations 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 from the Aetna Acquisition Date through December 31, 2018.

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, 2018; 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, 2018 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 United States 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 IBNR from the Aetna Acquisition Date through December 31, 2018. As of December 31, 2018, unpaid claims balances of \$816 million and \$1.9 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively.

Substantially all life and disability insurance liabilities have been fully ceded to unrelated third parties through indemnity reinsurance agreements; however, the Company remains directly obligated to the policyholders.

#### *Future policy benefits*

Future policy benefits consist primarily of reserves for limited payment pension and annuity contracts, long-duration group life and long-term care insurance contracts. Reserves for limited payment pension and annuity contracts are computed using actuarial principles that consider, among other things, assumptions reflecting anticipated mortality, retirement, expense and interest rate experience. Such assumptions generally vary by plan, year of issue and policy duration. Assumed interest rates on such contracts ranged from 3.5% to 11.3% from the Aetna Acquisition Date through December 31, 2018. The Company periodically reviews mortality assumptions against both industry standards and its experience. Reserves for long-duration long-term care contracts represent the Company's estimate of the present value of future benefits to be paid to or on behalf of policyholders less the present value of future net premiums. The assumed interest rate on such contracts was 5.1% from the Aetna Acquisition Date through December 31, 2018. The Company's estimate of the present value of future benefits under such contracts is based upon mortality, morbidity and interest rate assumptions. As of December 31, 2018, future policy benefits

balances of \$536 million and \$6.2 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively.

### ***Premium Deficiency Reserves***

The Company evaluates its insurance contracts to determine if it is probable that a loss will be incurred. A premium deficiency loss is recognized when it is probable that expected future claims, including maintenance costs (for example, direct costs such as claim processing costs), will exceed existing reserves plus anticipated future premiums and reinsurance recoveries. Anticipated investment income is considered in the calculation of premium deficiency losses for short-duration contracts. For purposes of determining premium deficiency losses, contracts are grouped consistent with the Company's method of acquiring, servicing and measuring the profitability of such contracts. The Company established a premium deficiency reserve of \$16 million as of December 31, 2018 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 credited interest thereon, net of experience-rated adjustments. From the Aetna Acquisition Date through December 31, 2018, interest rates for pension and annuity investment contracts ranged from 3.5% to 13.4%. Reserves for contracts subject to experience rating reflect the Company's rights as well as the rights of policyholders and plan participants. The Company also holds funds for health savings accounts ("HSAs") on behalf of members associated with high deductible health plans. These amounts are held to pay for qualified health care expenses incurred by these members. The HSA balances were approximately \$2.1 billion at December 31, 2018 and are reflected in other current assets with a corresponding liability in policyholder 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, 2018 and 2017, self-insurance liabilities totaled \$865 million and \$696 million, respectively, and were recorded as accrued expenses on the consolidated balance sheets.

### ***Facility Opening and Closing Costs***

New facility opening costs, other than capital expenditures, are charged directly to expense when incurred. When the Company closes a facility, the present value of estimated unrecoverable costs, including the remaining lease obligation less estimated sublease income and the book value of abandoned property and equipment, are charged to expense.

In December 2016, the Company announced an enterprise streamlining initiative designed to reduce costs and enhance operating efficiencies to allow the Company to be more competitive in the current health care environment. During the year ended December 31, 2017, in connection with that enterprise streamlining initiative, the Company closed 71 retail stores and recorded charges of \$215 million within operating expenses in the Retail/LTC segment. The charges are primarily comprised of provisions for the present value of noncancelable lease obligations. The noncancelable lease obligations associated with stores closed during the year ended December 31, 2017 extend through the year 2039. During the year ended December 31, 2018, the Company did not recognize any significant charges related to facility closing costs.

The long-term portion of the lease obligations associated with all outstanding facility closings was \$269 million and \$306 million as of December 31, 2018 and 2017, respectively, and was recorded in other long-term liabilities on the consolidated balance sheets.

### ***Contingent Consideration***

In December 2015, the Company acquired the pharmacy and clinic businesses of Target for approximately \$1.9 billion, plus contingent consideration of up to \$60 million based on future prescription growth over a three year period through December 31, 2019. As of December 31, 2018, no liability for any potential contingent consideration has been recorded based on historical and projected prescription growth through 2019.

### ***Redeemable Noncontrolling Interest***

As a result of the acquisition of Omnicare, Inc. (“Omnicare”) in 2015, the Company obtained a 73% ownership interest in a limited liability company (“LLC”). Due to the change in control in Omnicare, the noncontrolling member of the LLC had the contractual right to put its membership interest to the Company at fair value. Consequently, the noncontrolling interest in the LLC was recorded as a redeemable noncontrolling interest at fair value. During 2016, the noncontrolling member of the LLC exercised its option to sell its ownership interest and the Company purchased the noncontrolling interest in the LLC for approximately \$39 million.

Below is a summary of the changes in redeemable noncontrolling interest for the year ended December 31, 2016:

#### ***In millions***

Beginning balance	\$	39
Net income attributable to noncontrolling interest		1
Distributions		(2)
Purchase of noncontrolling interest		(39)
Reclassification to capital surplus in connection with purchase of noncontrolling interest		1
Ending balance	<u>\$</u>	<u>—</u>

### ***Foreign Currency Translation and Transactions***

For local currency functional currency, (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. Revenue and expense 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 income.

Gains and losses from foreign currency transactions and the effects of foreign currency remeasurements were not material in any of the periods presented.

### ***Revenue Recognition***

The following is a discussion of the Company’s revenue recognition policies by segment under the new revenue recognition accounting standard. See “New accounting pronouncements recently adopted - Revenue from Contracts with Customers” below for further discussion regarding the adoption of the new revenue recognition accounting standard. The new revenue recognition accounting standard does not relate to contracts within the scope of *Accounting Standards Codification 944 Financial Services - Insurance*. As a result, the majority of revenues within the Health Care Benefits segment and certain revenues within the Pharmacy Services segment are not within the scope of the new accounting standard.

#### ***Pharmacy Services Segment***

PSS 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 PSS, 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 United States Centers for Medicare & Medicaid Services (“CMS”) subsidized portion of prescription drugs dispensed to the Company’s Silverscript PDP members, (iii) the price paid to PSS 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 (iv) claims based administrative fees for retail pharmacy network contracts. Sales taxes are not included in revenue.

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 in exchange for those prescription drugs. The following revenue recognition policies have been established for PSS:

- 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 PSS acts as an agent or does not control the prescription drugs prior to transfer to the client, revenue is recognized using the net method.

#### Drug discounts

PSS records revenue net of manufacturers’ rebates earned by its clients based on their plan members’ utilization of brand-name formulary drugs. PSS 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. PSS 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 as 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 results of operations or financial condition.

#### Guarantees

PSS also adjusts revenues for refunds owed to the client 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 results of operations or financial condition.

#### Medicare Part D

PSS’ revenues include insurance premiums earned by the PDP, 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.

PSS’ 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, PSS 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.

#### *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 the third party payer for 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 results of operations 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 results of operations or financial condition. Sales taxes are not included in revenue.

##### Loyalty Program

The Company's customer loyalty program, ExtraCare<sup>®</sup>, is comprised of two components, ExtraSavings<sup>™</sup> and ExtraBucks<sup>®</sup> 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 rewards are reflected as a contract liability.

##### 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 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 the revenue from sales of pharmaceutical and medical products are 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 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 are typically 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*

##### Premium Revenue

HCBS premiums are recognized as income in the month in which the enrollee is entitled to receive health care services. Premiums are reported net of an allowance for estimated terminations and uncollectible amounts. Additionally, premium revenue subject to the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010's (as amended, collectively, the "ACA's") minimum medical loss ratio ("MLR") rebate requirements is recorded net of the estimated minimum MLR rebates for the current calendar year. Premiums related to unexpired contractual coverage periods (unearned premiums) are reported as other insurance liabilities on the consolidated balance sheets and recognized as revenue when earned.

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

#### Services and Product Revenue

HCBS services and product revenue relates to contracts that can include various combinations of products, services, or series of services, which are generally capable of being distinct and accounted for as separate performance obligations. HCBS' services and product revenue consists of the following components:

- ASC fees are received in exchange for performing certain claim processing and member services for HCBS' ASC medical members. ASC fee revenue is recognized over the period the service is provided. Some of the 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, HCBS is financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk is typically limited to a percentage of the fees otherwise payable to the Company by the customer involved. Each period HCBS estimates obligations under the terms of these guarantees and records its estimate as an offset to service revenues.
- Workers' compensation administrative services consist of fee-based managed care services. Workers' compensation administrative services revenue is recognized once the service is provided.
- Specialty and home delivery pharmacy product revenue is recognized when the prescription is delivered to an ASC member. Specialty and home delivery pharmacy product revenue reflects the price of the prescription on a gross basis (ASC member co-payments and plan sponsor reimbursements).

#### Accounting for Medicare Part D

HCBS offers Medicare Part D prescription drug insurance coverage under contracts with the CMS. HCBS' revenue recognition policy for Medicare Part D is consistent with the policy detailed in the "*Medicare Part D*" section of PSS' revenue recognition policy described above.

### Disaggregation of Revenue

The following table disaggregates the Company's revenue by major source in each segment for the year ended December 31, 2018:

<i><u>In millions</u></i>	<b>Pharmacy Services</b>	<b>Retail/LTC</b>	<b>Health Care Benefits</b>	<b>Corporate/Other</b>	<b>Intersegment Eliminations</b>	<b>Consolidated Totals</b>
Major goods/services lines:						
Pharmacy	\$ 130,195	\$ 64,179	\$ 164	\$ —	\$ (29,693)	\$ 164,845
Front Store	—	19,055	—	—	—	19,055
Premiums	3,361	—	4,819	4	—	8,184
Net investment income	13	—	45	602	—	660
Other	559	755	521	—	—	1,835
<b>Total</b>	<b>\$ 134,128</b>	<b>\$ 83,989</b>	<b>\$ 5,549</b>	<b>\$ 606</b>	<b>\$ (29,693)</b>	<b>\$ 194,579</b>

#### Pharmacy Services distribution channel:

Mail choice <sup>(1)</sup>	\$ 46,934
Pharmacy network <sup>(2)</sup>	83,261
Other	3,933
<b>Total</b>	<b>\$ 134,128</b>

- (1) Pharmacy Services mail choice is defined as claims filled at a Pharmacy Services mail facility, which includes specialty mail claims inclusive of Specialty Connect<sup>®</sup> claims picked up at a CVS Pharmacy retail store, as well as prescriptions filled at the Company's retail pharmacies under the Maintenance Choice<sup>®</sup> program, which 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 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.

### 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, for example ExtraBucks<sup>®</sup> 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:

<i><u>In millions</u></i>	<b>2018</b>	<b>2017</b>
Trade receivables (included in accounts receivable, net)	\$ 6,896	\$ 7,895
Contract liabilities (included in accrued expenses)	67	53

During the year ended December 31, 2018, 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:

<i><u>In millions</u></i>	
Balance at December 31, 2017	\$ 53
Adoption of ASU 2014-09	17
Loyalty program earnings and gift card issuances	332
Redemption and breakage	(335)
<b>Balance at December 31, 2018</b>	<b>\$ 67</b>

### ***Cost of products sold***

The Company accounts for cost of products sold as follows:

#### ***Pharmacy Services Segment***

PSS' cost of products sold includes: (i) the cost of prescription drugs sold during the reporting period directly through its mail service dispensing pharmacies and indirectly through its retail pharmacy network, (ii) shipping and handling costs, and (iii) the operating costs of its 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 PSS' 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 PSS' retail pharmacy network under contracts where it is the principal, net of any volume-related or other discounts.

#### ***Retail/LTC Segment***

RLS' 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.

#### ***Health Care Benefits Segment***

HCBS' cost of products sold includes the cost of the prescription and certain administrative costs incurred for dispensing the prescription to ASC members by HCBS' specialty and home delivery pharmacy operations.

See Note 17 "Segment Reporting" for additional information about the cost of products sold of the Company's segments.

### ***Vendor allowances and purchase discounts***

The Company accounts for vendor allowances and purchase discounts as follows:

#### ***Pharmacy Services Segment***

PSS receives purchase discounts on products purchased. PSS' contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for PSS 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 after 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 PSS' results of operations. PSS accounts for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. PSS also receives additional discounts under its wholesaler contracts if it exceeds contractually defined annual purchase volumes. In addition, PSS 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 RLS 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 also is initially deferred. The deferred amounts are then amortized to reduce cost of products sold on a straight-line basis over the life of the related contract. The total amortization of these upfront payments was not material to the Company's consolidated financial statements in any of the periods presented.

## ***Health Care Reform***

### ***Health Insurer Fee***

Since January 1, 2014, the ACA imposes an annual premium-based health insurer fee (“HIF”) for each calendar year payable in September which is not deductible for tax purposes. The Company is required to estimate a liability for the HIF at the beginning of the calendar year in which the fee is payable with a corresponding deferred asset that is amortized ratably to operating expenses over the calendar year. The Company records the liability for the health insurer fee in accrued expenses and records the deferred asset in other current assets. In 2018 and 2016, operating expenses include \$157 million and \$56 million, respectively, related to the Company’s share of the HIF. There was no expense related to the HIF in 2017 and there will be no expense for HIF in 2019, since the HIF was suspended for each of those periods.

### ***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, the Company estimates its ultimate risk adjustment receivable (recorded in accounts receivable) or payable (recorded in accrued expenses) for the current calendar year and reflects the pro-rata year-to-date impact as an adjustment to premium revenue.

### ***Advertising costs***

Advertising costs are expensed when the related advertising takes place. Advertising costs, net of vendor funding (included in operating expenses), were \$364 million, \$230 million and \$216 million in 2018, 2017 and 2016, respectively.

### ***Stock-based compensation***

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as an expense over the applicable requisite service period of the stock award (generally 3 to 5 years) using the straight-line method.

### ***Income taxes***

The Company accounts for income taxes under the asset and liability method, which requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of events that have been included in the consolidated financial statements. Under this method, deferred tax assets and liabilities are determined on the basis of the differences between the consolidated financial statements and tax basis of assets and liabilities using enacted tax rates in effect for the year or years in which the differences are expected to reverse. The effect of a change in the tax rates on deferred tax assets and liabilities is recognized in income in the period that includes the enactment date of such change.

The Tax Cuts and Jobs Act (the “TCJA”) was enacted on December 22, 2017. Among numerous changes to existing tax laws, the TCJA permanently reduced the federal corporate income tax rate from 35% to 21% effective January 1, 2018. The effects of changes in tax rates on deferred tax balances are required to be taken into consideration in the period in which the changes are enacted, regardless of when they are effective. As a result of the reduction of the corporate income tax rate under the TCJA, the Company estimated the revaluation of its net deferred tax liabilities and recorded a provisional noncash income tax benefit of approximately \$1.5 billion for year ended December 31, 2017. The Company completed its assessment of the TCJA’s final impact in December 2018 and recorded an additional tax benefit of approximately \$100 million in the year ended December 31, 2018.

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 recent results of operations. 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 (“OPEB”) Plans***

The Company sponsors defined benefit pension plans (“pension plans”) and OPEB plans for its employees and retirees. The Company recognizes the funded status of its pension plans 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 plans benefit obligations, the amounts are reported in other current assets and other assets. When the fair value of 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. Nearly all of the Company’s net benefit costs for the Company’s defined benefit pension and postretirement plans do not contain a service cost component as most of these defined benefit plans have been frozen for an extended period of time. Non-service components of pension and postretirement benefit cost are included in other expense (income) in the consolidated statements of operations.

## ***Earnings per common 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 December 31, 2018 and 2017, respectively. 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) real estate partnerships that are considered VIE’s. The Company does not have a future obligation to fund losses or debts on behalf of these investments; however, it may voluntarily contribute funds. In evaluating whether the Company is the primary beneficiary of a VIE, the Company considers several factors, including whether the Company has (a) the power to direct the activities that most significantly impact the VIE’s economic performance and (b) the obligation to absorb losses and the right to receive benefits that could potentially be significant to the VIE.

### ***Variable Interest Entities - Primary Beneficiary***

In 2014, the Company and Cardinal Health, Inc. (“Cardinal”) established Red Oak Sourcing, LLC (“Red Oak”), a generic pharmaceutical sourcing entity in which the Company and Cardinal each own 50%. The Red Oak arrangement has an initial term of 10 years. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak; however, Red Oak does not own or hold inventory on behalf of either company. No physical assets (e.g., property and equipment) were contributed to Red Oak by either company, and minimal funding was provided to capitalize Red Oak. The Company has determined that it is the primary beneficiary of this VIE because it has the ability to direct the activities of Red Oak. Consequently, the Company consolidates Red Oak in its consolidated financial statements within the Retail/LTC segment.

Cardinal is required to pay the Company 39 quarterly payments beginning in October 2014. As milestones are met, the quarterly payments increase. The Company received from Cardinal approximately \$183 million during each of the years ended December 31, 2018 and 2017 and \$163 million during the year ended December 31, 2016. 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, 2018, 2017 and 2016, as well as amounts due to or due from Cardinal at December 31, 2018 and 2017 were immaterial.

### ***Variable Interest Entities - Other Variable Interest Holder***

In November 2018, the Company completed the Aetna Acquisition. Aetna has involvement with VIEs where the Company 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 investments 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 sheet and recognizes its share of each VIE’s income or losses in earnings. 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 sheet at December 31, 2018 was as follows:

<i><b><u>In millions</u></b></i>	
Hedge fund investments	\$ 270
Private equity investments	524
Real estate partnerships	275
Total	<u>\$ 1,069</u>

### ***Related Party Transactions***

The Company has an equity method investment in SureScripts, LLC (“SureScripts”), which operates a clinical health information network. PSS and RLS utilize this clinical health information network in providing services to their respective client plan members and retail customers. The Company expensed fees for the use of this network of approximately \$45 million, \$35 million and \$39 million in the years ended December 31, 2018, 2017 and 2016, respectively. The Company’s investment in and equity in the earnings of SureScripts for all periods presented is immaterial.

The Company has an equity method investment in Heartland Healthcare Services (“Heartland”). Heartland operates several LTC pharmacies in four states. Heartland paid the Company approximately \$135 million, \$139 million and \$140 million for pharmaceutical inventory purchases during the years ended December 31, 2018, 2017 and 2016, respectively. Additionally, the Company performs certain collection functions for Heartland and then passes those customer cash collections back to Heartland. The Company’s investment in and equity in the earnings of Heartland for all periods presented is immaterial.

### ***Discontinued Operations***

In connection with certain business dispositions completed between 1991 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Bob’s Stores and Linens ‘n Things each of which subsequently filed for bankruptcy. The Company’s loss from discontinued operations primarily includes lease-related costs which the Company believes it will likely be required to satisfy pursuant to its lease guarantees. See “Lease Guarantees” in Note 16 “Commitments and Contingencies” for more information.

Results from discontinued operations were immaterial for the year ended December 31, 2018. Below is a summary of the results of discontinued operations for the years ended December 31, 2017 and 2016:

<i><b><u>In millions</u></b></i>	<b><u>2017</u></b>	<b><u>2016</u></b>
Loss from discontinued operations	\$ (13)	\$ (2)
Income tax benefit	5	1
Loss from discontinued operations, net of tax	<u>\$ (8)</u>	<u>\$ (1)</u>

### ***New accounting pronouncements recently adopted***

#### *Revenue from Contracts with Customers*

In May 2014, the Financial Accounting Standards Board (“FASB”) issued Accounting Standards Update (“ASU”) 2014-09, *Revenue from Contracts with Customers* (Topic 606) (“Topic 606”). ASU 2014-09 outlines a single comprehensive model for

companies to use in accounting for revenue arising from contracts with customers and supersedes most current revenue recognition guidance, including industry-specific guidance. In March 2016, the FASB issued ASU 2016-08, *Principal Versus Agent Considerations (Reporting Revenue Gross Versus Net)* which amends the principal-versus-agent implementation guidance and in April 2016 the FASB issued ASU 2016-10, *Identifying Performance Obligations and Licensing*, which amends the guidance in those areas in the new revenue recognition standard.

The Company adopted the new standard as of January 1, 2018 using the modified retrospective method and applied the new standard to all contracts. Therefore, the comparative financial information has not been restated and continues to be reported under the accounting standards in effect for the applicable period. While the adoption of the new standard did not result in any material adjustments to the Company's revenue or net income, one difference was identified between the previous accounting guidance and the new accounting guidance in RLS related to the accounting for the Company's ExtraBucks<sup>®</sup> Rewards customer loyalty program. This program was previously accounted for under a cost deferral method, while under the new standard this program is accounted for under a revenue deferral method. The cumulative effect of applying the new guidance to all contracts was recorded as an adjustment to retained earnings as of the adoption date.

As a result of applying the modified retrospective method to adopt the new standard, the following adjustments were made to accounts on the consolidated balance sheet as of January 1, 2018:

<u><i>In millions</i></u>	<b>Impact of Change in Accounting Policy</b>		
	<b>As Reported</b>		<b>Adjusted</b>
	<b>December 31, 2017</b>	<b>Adjustments</b>	<b>January 1, 2018</b>
<b>Consolidated Balance Sheet:</b>			
Accrued expenses	\$ 6,581	\$ 17	\$ 6,598
Deferred income taxes	2,996	(4)	2,992
Total liabilities	57,436	13	57,449
Retained earnings	43,556	(13)	43,543
Total CVS Health shareholders' equity	37,691	(13)	37,678
Total shareholders' equity	37,695	(13)	37,682

The following tables compare the reported consolidated balance sheet, statements of operations, and statement of cash flows amounts to the pro forma amounts had the previous revenue accounting guidance remained in effect:

<i>In millions</i>	Impact of Change in Accounting Policy		
	As Reported As of/For the Year Ended December 31, 2018	Adjustments	Balances Without Adoption of Topic 606
Consolidated Statement of Operations:			
Revenues:			
Products	\$ 183,910	\$ 3	\$ 183,913
Total revenues	194,579	3	194,582
Operating costs:			
Cost of products sold	156,447	2	156,449
Total operating costs	190,558	2	190,560
Operating income	4,021	1	4,022
Income before income tax provision	1,406	1	1,407
Income tax provision	2,002	—	2,002
Loss from continuing operations	(596)	1	(595)
Net loss	(596)	1	(595)
Net loss attributable to CVS Health	(594)	1	(593)
Consolidated Balance Sheet:			
Accrued expenses	10,711	(18)	10,693
Total current liabilities	44,009	(18)	43,991
Deferred income taxes	7,677	4	7,681
Total liabilities	137,913	(14)	137,899
Retained earnings	40,911	14	40,925
Total CVS Health shareholders' equity	58,225	14	58,239
Total shareholders' equity	58,543	14	58,557
Consolidated Statement of Cash Flow:			
Reconciliation of net loss to net cash provided by operating activities:			
Net loss	(596)	1	(595)
Other liabilities	165	(1)	164

#### *Recognition and Measurement of Financial Assets and Financial Liabilities*

In January 2016, the FASB issued ASU 2016-01, *Financial Instruments - Overall* (Subtopic 825-10): *Recognition and Measurement of Financial Assets and Financial Liabilities*. This ASU requires equity investments, except those under the equity method of accounting or those that result in the consolidation of an investee, to be measured at fair value with changes in fair value recognized in net income. However, an entity may choose to measure equity investments that do not have readily determinable fair values at cost minus impairment, if any, plus or minus changes resulting from observable price changes in orderly transactions for the identical or similar investment of the same issuer. This simplifies the impairment assessment of equity investments previously held at cost. Entities are required to apply the guidance retrospectively, with the exception of the amendments related to equity investments without readily determinable fair values, which must be applied on a prospective basis. Effective January 1, 2018, the Company adopted this new accounting guidance. The adoption of this new guidance did not have a material impact on the Company's financial condition or results of operations.

#### *Classification of Certain Cash Receipts and Cash Payments in the Consolidated Statements of Cash Flows*

In August 2016, the FASB issued ASU 2016-15, *Classification of Certain Cash Receipts and Cash Payments*. This ASU is intended to add or clarify guidance on the classification of certain cash receipts and payments in the statement of cash flows and

to eliminate the diversity in practice related to such classifications. Effective January 1, 2018, the Company adopted this new accounting guidance. The adoption of this new guidance did not have a material impact on the Company's financial condition or results of operations.

*Statement of Cash Flows - Restricted Cash*

In November 2016, the FASB issued ASU 2016-18, *Statement of Cash Flows*, which amends Accounting Standard Codification Topic 230. This ASU requires entities to show the changes in the total of cash, cash equivalents, restricted cash and restricted cash equivalents in the statement of cash flows. As a result, entities no longer are required to present transfers between cash and cash equivalents and restricted cash and restricted cash equivalents in the statement of cash flows. When cash, cash equivalents, restricted cash and restricted cash equivalents are presented in more than one line item on the balance sheet, the new guidance requires a reconciliation of the totals in the statement of cash flows to the related captions in the balance sheet. Entities will also have to disclose the nature of their restricted cash and restricted cash equivalent balances. The guidance is required to be applied retrospectively. Effective January 1, 2018, the Company adopted this new accounting guidance.

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

<u><i>In millions</i></u>	<u>2018</u>	<u>2017</u>	<u>2016</u>
Cash and cash equivalents	\$ 4,059	\$ 1,696	\$ 3,371
Restricted cash (included in other current assets)	6	14	—
Restricted cash (included in other assets)	230	190	149
Total cash, cash equivalents and restricted cash at the end of the period in the statement of cash flows	<u>\$ 4,295</u>	<u>\$ 1,900</u>	<u>\$ 3,520</u>

See "Restricted cash" above for further discussion of the nature of the Company's restricted cash and restricted cash equivalent balances.

The following is a reconciliation of the effect on the relevant line items in the consolidated statement of cash flows for the years ended December 31, 2017 and 2016 as a result of adopting this new accounting guidance:

<u><i>In millions</i></u>	<u>As Previously</u>		
	<u>Reported</u>	<u>Adjustments</u>	<u>As Revised</u>
<b>Year Ended December 31, 2017</b>			
Acquisitions (net of cash acquired)	\$ (1,236)	\$ 55	\$ (1,181)
Net cash used in investing activities	(2,932)	55	(2,877)
Net decrease in cash, cash equivalents and restricted cash <sup>(1)</sup>	(1,675)	55	(1,620)
Cash, cash equivalents and restricted cash at the beginning of the period <sup>(1)</sup>	3,371	149	3,520
Cash, cash equivalents and restricted cash at the end of the period <sup>(1)</sup>	1,696	204	1,900
<b>Year Ended December 31, 2016</b>			
Acquisitions (net of cash acquired)	(524)	—	(524)
Net cash used in investing activities	(2,470)	—	(2,470)
Net decrease in cash, cash equivalents and restricted cash <sup>(1)</sup>	912	—	912
Cash, cash equivalents and restricted cash at the beginning of the period <sup>(1)</sup>	2,459	149	2,608
Cash, cash equivalents and restricted cash at the end of the period <sup>(1)</sup>	3,371	149	3,520

(1) Prior to the adoption of ASU 2016-18, these financial statement captions excluded restricted cash. The financial statement captions have been renamed to reflect the inclusion of restricted cash subsequent to the adoption of ASU 2016-18 on January 1, 2018.

*Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income*

In February 2018, the FASB issued ASU 2018-02, *Income Statement - Reporting Comprehensive Income (Topic 220): Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income ("ASU 2018-02")*. This ASU permits entities to reclassify tax effects stranded in accumulated other comprehensive income as a result of the TCJA to retained

earnings. The guidance states that because the adjustment of deferred income taxes due to the reduction of the historical corporate income tax rate to the newly enacted corporate income tax rate was required to be included in income from continuing operations, the tax effects of items within accumulated other comprehensive income (“stranded tax effects”) are not reflected at the appropriate tax rate. During the first quarter of 2018, the Company elected to early adopt this new standard and decreased accumulated other comprehensive income and increased retained earnings in the period of adoption by \$7 million due to the change in the United States federal corporate income tax rate enacted in December 2017. See Note 13 “Other Comprehensive Income (Loss)” for the impact of the adoption of this guidance on accumulated other comprehensive income for the year ended December 31, 2018.

### ***New accounting pronouncements not yet adopted***

#### *Leases*

In February 2016, the FASB issued ASU 2016-02, *Leases* (Topic 842). Lessees will be required to recognize a right-of-use asset and a lease liability for virtually all of their leases (other than leases that meet the definition of a short-term lease). The liability will be equal to the present value of future lease payments. The asset will be based on the liability, subject to adjustment, such as for initial direct costs. For income statement purposes, a dual model was retained, requiring leases to be classified as either operating or finance leases. Operating leases will result in straight-line expense (similar to current operating leases) while finance leases will result in a front-loaded expense pattern (similar to current capital leases). Lessor accounting is similar to the current model, but updated to align with certain changes to the lessee model (e.g., certain definitions, such as initial direct costs, have been updated) and the new revenue recognition standard. The Company adopted this new accounting guidance on January 1, 2019 on a modified retrospective basis. The adoption of this new guidance resulted in an increase in both assets and liabilities of approximately \$20 billion as of January 1, 2019. The adoption of this new guidance is not expected to have a material impact on the Company’s results of operations or cash flows.

#### *Accounting for Interest Associated with the Purchase of Callable Debt Securities*

In March 2017, the FASB issued ASU 2017-08, *Accounting for Interest Associated with the Purchase of Callable Debt Securities* (Topic 310). Under this ASU, premiums on callable debt securities are amortized to the earliest call date rather than to the contractual maturity date. Callable debt securities held at a discount will continue to be amortized to the contractual maturity date. The Company adopted this new accounting guidance on January 1, 2019 on a modified retrospective basis and recorded an immaterial cumulative effect adjustment from accumulated other comprehensive income to retained earnings on the consolidated balance sheet.

#### *Measurement of Credit Losses on Financial Instruments*

In June 2016, the FASB issued ASU 2016-13, *Financial Instruments - Credit Losses* (Topic 326). This ASU requires the use of a forward-looking expected loss impairment model for trade and other receivables, held-to-maturity debt securities, loans and other instruments. The ASU also requires impairments and recoveries for available-for-sale debt securities to be recorded through an allowance account and revises certain disclosure requirements. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2019. The Company is currently evaluating the effect that implementation of this standard will have on the Company’s consolidated results of operations, cash flows, financial condition and related disclosures.

#### *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*. The new standard requires a customer in a cloud computing arrangement that is a service contract to follow internal-use software guidance in Topic 350-40 to determine which implementation costs to capitalize as assets. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2019. Early adoption is permitted. The Company is currently evaluating the effect the implementation of this standard will have on the Company’s consolidated results of operations, cash flows, financial condition and 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 Insurance Contracts* (Topic 944). The ASU 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. The Company is also required 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. In addition, the new guidance 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, 2020. The Company is currently evaluating the effect the implementation of this standard will have on the Company's consolidated results of operations, cash flows, financial condition and related disclosures.

## 2. 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. Aetna is a leading health care benefits company that offers a broad range of traditional, voluntary, and consumer-directed health insurance products and related services. The majority of Aetna's operations are included in a new segment, Health Care Benefits. The Health Care Benefits segment is the equivalent of the former Aetna Health Care Segment. The remainder 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 Corporate/Other segment. 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 fair value of the consideration transferred on the date of acquisition consisted of the following:

### In millions

Cash	\$ 48,089
Common stock (274.4 million shares) <sup>(1)</sup>	22,117
Fair value of replacement equity awards for pre-combination services (9.9 million shares) <sup>(2)</sup>	367
Effective settlement of pre-existing relationship <sup>(3)</sup>	(807)
<b>Total consideration transferred</b>	<b>\$ 69,766</b>

- (1) The fair value of the Company's common stock issued as consideration was calculated based on the 327.6 million Aetna common shares outstanding as of November 28, 2018 multiplied by (i) the merger agreement per share exchange ratio and (ii) the volume weighted average price of CVS Health common stock on November 28, 2018 of \$80.59.
- (2) The fair value of the replacement equity awards issued by the Company was determined as of the Aetna Acquisition Date. The fair value of the awards attributed to pre-combination services of \$367 million is included in the consideration transferred and the fair value of the awards attributed to post-combination services of \$232 million has been, or will be, included in the Company's post-combination financial statements as compensation costs.
- (3) The purchase price included \$807 million of effectively settled liabilities the Company owed to Aetna from their pre-existing pharmacy services relationship.

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 estimated fair values of the assets acquired and liabilities assumed at the date of acquisition:

***In millions***

Cash and cash equivalents	\$ 6,565
Accounts receivable <sup>(1)</sup>	4,089
Other current assets	3,896
Investments (current and long-term)	17,991
Goodwill	46,684
Intangible assets	23,746
Other long-term assets	8,282
Total assets acquired	<u>111,253</u>
Health care costs payable	5,359
Other current liabilities	10,026
Debt (current and long-term)	8,098
Deferred income taxes	4,574
Other long-term liabilities	13,101
Total liabilities assumed	<u>41,158</u>
Noncontrolling interests	329
Total consideration transferred	<u>\$ 69,766</u>

(1) The fair value of premium receivables acquired is \$2.4 billion, with the gross contractual amount being \$2.8 billion. The Company expects \$424 million of premium receivables to be uncollectible. The fair value of other receivables acquired is \$1.7 billion, with the gross contractual amount being \$1.8 billion. The Company expects \$84 million of other receivables to be uncollectible.

The assessment of fair value is preliminary and is based on information that was available to management at the time the consolidated financial statements were prepared. The most significant open items included the valuation of certain intangible assets and investments, the accounting for income taxes and the accounting for contingencies as management is awaiting additional information to complete its assessment of these matters. Measurement period adjustments will be recorded in the period in which they are determined, as if they had been completed at the acquisition date. The finalization of the Company's purchase accounting assessment could result in changes in the valuation of assets acquired and liabilities assumed, which could be material.

***Goodwill***

Goodwill represents future economic benefits expected to arise from the Company's expanded presence in the health care industry, the assembled workforce acquired, expected purchasing, medical cost and revenue synergies, as well as operating efficiencies and cost savings. The preliminary valuation of goodwill was allocated to the Company's business segments as follows:

***In millions***

Health Care Benefits	\$ 44,484
Pharmacy Services	1,500
Retail/LTC	700
Total goodwill	<u>\$ 46,684</u>

Approximately \$165 million of goodwill is deductible for income tax purposes.

### *Intangible Assets*

The following table summarizes the preliminary fair values and weighted average useful lives for intangible assets acquired in the Aetna Acquisition, each of which is subject to change as the Company finalizes its purchase accounting:

<i><u>In millions, except weighted average useful life</u></i>	<b>Gross Fair Value</b>	<b>Weighted Average Useful Life (years)</b>
Customer relationships <sup>(1)</sup>	\$ 13,630	14.4
Standalone Medicare Part D prescription drug plan customer relationship (held for sale)	101	N/A
Technology	1,060	3.0
Provider networks <sup>(1)</sup>	4,200	20.0
Value of Business Acquired	590	20.0
Trademark (definite-lived)	65	5.0
Trademark (indefinitely-lived)	4,100	N/A
Total intangible assets	<u>\$ 23,746</u>	<u>15.1</u>

- (1) The amortization period for the Company's customer relationships and provider networks includes an assumption of renewal or extension of these arrangements. At the acquisition date, the periods prior to the next renewal or extension for provider networks primarily ranged from one to three years, and the period prior to the next renewal or extension for customer relationships was one year. Any costs related to the renewal or extension of these contracts are expensed as incurred.

### *Deferred income taxes*

The purchase price allocation includes net deferred tax liabilities of \$4.6 billion, primarily relating to deferred tax liabilities established on the identifiable acquired intangible assets.

### *Consolidated results of operations*

The Company's consolidated results of operations for the year ended December 31, 2018, include \$5.6 billion of revenues and \$146 million of income before income tax provision associated with the results of operations of Aetna from the Aetna Acquisition Date to December 31, 2018.

During the year ended December 31, 2018 and 2017, the Company incurred transaction costs of \$147 million and \$34 million, respectively, associated with the Aetna Acquisition that were recorded within operating expenses.

### *Unaudited pro forma financial information*

The following unaudited pro forma information presents a summary of the Company's combined results of operations for the years ended December 31, 2018 and 2017 as if the Aetna acquisition and the related financing transactions had occurred on January 1, 2017. The following pro forma financial information is not necessarily indicative of the results of operations 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, but not limited to, differences between the assumptions used to prepare the pro forma 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.

<i><u>In millions, except per share data</u></i>	<b>Year Ended December 31,</b>	
	<b>2018</b>	<b>2017</b>
Total revenues	\$ 243,398	\$ 236,000
Income from continuing operations	1,123	6,813
Basic earnings per share from continuing operations attributable to CVS Health	\$ 0.87	\$ 5.25
Diluted earnings per share from continuing operations attributable to CVS Health	\$ 0.86	\$ 5.21

The pro forma results for the years ended December 31, 2018 and 2017 include adjustments related to the following purchase accounting and acquisition-related items:

- Elimination of intercompany transactions between CVS Health and Aetna;

- Elimination of estimated foregone interest income associated with (i) cash assumed to have been used to partially fund the Aetna Acquisition and (ii) adjusting the amortized cost of Aetna's investment portfolio to fair value as of the completion of the Aetna Acquisition;
- Elimination of historical intangible asset, deferred acquisition cost and capitalized software amortization expense and addition of amortization expense based on the current preliminary 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.

### 3. Investments

On November 28, 2018, the Company completed the Aetna Acquisition. Prior to the Aetna Acquisition Date, the Company's short term investments balance was comprised of certificates of deposit with initial maturities of greater than three months when purchased that mature in less than one year from the balance sheet date. These investments totaled \$111 million as of December 31, 2017 and were classified as available for sale. In addition, the Company had \$112 million of additional long-term investments as of December 31, 2017 which primarily consisted of cost method and equity method investments. Since the total amount of investments prior to the Aetna Acquisition was not material to the consolidated financial statements, the Company will include additional disclosures for investments on a prospective basis starting from the Aetna Acquisition Date.

Total investments at December 31, 2018 were as follows:

<i><b>In millions</b></i>	<b>Current</b>	<b>Long-term</b>	<b>Total</b>
Debt securities available for sale	\$ 2,359	\$ 12,896	\$ 15,255
Mortgage loans	145	1,216	1,361
Other investments	18	1,620	1,638
<b>Total investments</b>	<b>\$ 2,522</b>	<b>\$ 15,732</b>	<b>\$ 18,254</b>

At December 31, 2018, the Company held investments of \$531 million 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, 2018 were as follows:

<u>In millions</u>	<u>Amortized Cost</u>	<u>Gross Unrealized Gains</u>	<u>Gross Unrealized Losses</u>	<u>Fair Value</u>
<b>December 31, 2018</b>				
Debt securities:				
U.S. government securities	\$ 1,662	\$ 26	\$ —	\$ 1,688
States, municipalities and political subdivisions	2,370	30	(1)	2,399
U.S. corporate securities	6,444	61	(16)	6,489
Foreign securities	2,355	31	(3)	2,383
Residential mortgage-backed securities	567	10	—	577
Commercial mortgage-backed securities	594	11	—	605
Other asset-backed securities	1,097	3	(15)	1,085
Redeemable preferred securities	30	—	(1)	29
Total debt securities <sup>(1)</sup>	<u>\$ 15,119</u>	<u>\$ 172</u>	<u>\$ (36)</u>	<u>\$ 15,255</u>

(1) Investment risks associated with the Company's experience-rated products generally do not impact the Company's consolidated results of operations. At December 31, 2018, debt securities with a fair value of \$916 million, gross unrealized capital gains of \$12 million and gross unrealized capital losses of \$2 million were included in total debt securities, but support experience-rated products.

The fair value of debt securities at December 31, 2018 is 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.

<u>In millions</u>	<u>Amortized Cost</u>	<u>Fair Value</u>
Due to mature:		
Less than one year	\$ 901	\$ 902
One year through five years	5,489	5,521
After five years through ten years	2,973	2,999
Greater than ten years	3,498	3,566
Residential mortgage-backed securities	567	577
Commercial mortgage-backed securities	594	605
Other asset-backed securities	1,097	1,085
Total	<u>\$ 15,119</u>	<u>\$ 15,255</u>

### *Mortgage-Backed and Other Asset-Backed Securities*

All of the Company's residential mortgage-backed securities at December 31, 2018 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 United States Government. At December 31, 2018, the Company's residential mortgage-backed securities had an average credit quality rating of AAA and a weighted average duration of 4.8 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, 2018, these securities had an average credit quality rating of AAA and a weighted average duration of 6.3 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, 2018, these securities had an average credit quality rating of AA and a weighted average duration of 1.3 years.

Summarized below are the debt securities the Company held at December 31, 2018 that were in an unrealized capital loss position:

<i><u>In millions, except number of securities</u></i>	<b>Number of Securities</b>	<b>Fair Value</b>	<b>Unrealized Losses</b>
Debt securities:			
U.S. government securities	8	\$ 26	\$ —
States, municipalities and political subdivisions	54	86	1
U.S. corporate securities	1,399	1,431	16
Foreign securities	243	314	3
Residential mortgage-backed securities	45	1	—
Other asset-backed securities	516	528	15
Redeemable preferred securities	14	23	1
Total debt securities	<u>2,279</u>	<u>\$ 2,409</u>	<u>\$ 36</u>

Since Aetna's investment portfolio was measured at fair value as of the Aetna Acquisition Date, each of the securities in the table above were in an unrealized loss position for less than 12 months. 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 businesses. 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, 2018, 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 anticipated recovery of their amortized cost basis.

The maturity dates for debt securities in an unrealized capital loss position at December 31, 2018 were as follows:

<i><u>In millions</u></i>	<b>Supporting experience- rated products</b>		<b>Supporting remaining products</b>		<b>Total</b>	
	<b>Fair Value</b>	<b>Unrealized Losses</b>	<b>Fair Value</b>	<b>Unrealized Losses</b>	<b>Fair Value</b>	<b>Unrealized Losses</b>
Due to mature:						
Less than one year	\$ 21	\$ —	\$ 308	\$ —	\$ 329	\$ —
One year through five years	36	2	557	5	593	7
After five years through ten years	47	—	492	9	539	9
Greater than ten years	49	—	370	5	419	5
Residential mortgage-backed securities	—	—	1	—	1	—
Other asset-backed securities	4	—	524	15	528	15
Total	<u>\$ 157</u>	<u>\$ 2</u>	<u>\$ 2,252</u>	<u>\$ 34</u>	<u>\$ 2,409</u>	<u>\$ 36</u>

### ***Mortgage Loans***

The Company's mortgage loans are collateralized by commercial real estate. From the Aetna Acquisition Date through December 31, 2018, the Company had the following activity in its mortgage loan portfolio:

<i><u>In millions</u></i>	
New mortgage loans	\$ 4
Mortgage loans fully-repaid	27
Mortgage loans foreclosed	—

The Company assesses mortgage loans on a regular basis for credit impairments, and annually assign a credit quality indicator to each loan. The Company's credit quality indicator is internally developed and categorizes its portfolio on a scale from 1 to 7. These indicators are based upon several factors, including current loan-to-value ratios, property condition, market trends, creditworthiness of the borrower and deal structure. The vast majority of the Company's mortgage loans fall into categories 2 to 4.

- *Category 1* - Represents loans of superior quality
- *Categories 2 to 4* - Represents loans where credit risk is minimal to acceptable; however, these loans may display some susceptibility to economic changes.
- *Categories 5 and 6* - Represents 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 most recent assessments at December 31, 2018, the Company's mortgage loans were given the following credit quality indicators:

**In millions, except credit ratings indicator**

1	\$ 42
2 to 4	1,301
5 and 6	18
7	—
<b>Total</b>	<b>\$ 1,361</b>

At December 31, 2018 scheduled mortgage loan principal repayments were as follows:

**In millions**

2019	\$ 145
2020	109
2021	269
2022	228
2023	83
Thereafter	527
<b>Total</b>	<b>\$ 1,361</b>

***Net Investment Income***

Sources of net investment income for the year ended December 31, 2018 were as follows:

**In millions**

Debt securities	\$ 637
Mortgage loans	6
Other investments	17
Gross investment income	660
Investment expenses	(3)
Net investment income (excluding net realized capital gains or losses)	657
Net realized capital gains	3
Net investment income <sup>(1)</sup>	<b>\$ 660</b>

(1) Net investment income in 2018 includes \$4 million related to investments supporting experience-rated products.

The Company's net investment income was \$21 million and \$20 million in 2017 and 2016, respectively, relating to interest income on debt securities. The Company did not have any material realized capital gains or losses during 2017 or 2016.

The portion of unrealized capital gains and losses recognized during the year ended December 31, 2018 related to investments in equity securities held as of December 31, 2018 was 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 from the Aetna Acquisition Date through December 31, 2018 were as follows:<sup>(1)</sup>

***In millions***

Proceeds from sales	\$ 389
Gross realized capital gains	2
Gross realized capital losses	(2)

(1) The proceeds from sales and gross realized capital gains and losses exclude the impact of the sales of short-term debt securities which primarily relate to the Company's investments in mutual funds. These investments were excluded from the disclosed amounts because they represent an immaterial amount of aggregate gross realized capital gains or losses and have a high volume of sales activity.

**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 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 ("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 – 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, inputs that are observable that are not prices (such as interest rates and credit risks) and 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 would then be 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.

*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 United States 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, but are not limited to, quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets and inputs that are observable but not prices (for example, 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 these prices at December 31, 2018. The Company's Level 2 debt securities were not material as of December 31, 2017.

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 obtained one non-binding broker quote for each of these Level 3 debt securities and did not adjust any of these quotes at December 31, 2018. The total fair value of broker quoted debt securities was \$50 million at December 31, 2018. The Company did not have any Level 3 debt securities as of December 31, 2017. Examples of these broker quoted Level 3 debt securities include certain United States and foreign corporate securities and certain of the Company's commercial mortgage-backed securities as well as other asset-backed securities. For some private placement securities, the Company's internal staff determines the value of these debt securities by analyzing spreads of corporate and sector indices as well as interest spreads of comparable public bonds. Examples of these private placement Level 3 debt securities include certain United States and foreign securities and certain tax-exempt municipal securities.

*Equity Securities* – The Company currently has two classifications of equity securities: those that are publicly traded and those that are privately placed. Publicly-traded equity securities are classified in Level 1 because quoted prices are available for these securities in an active market. For privately placed equity securities, there is no active market; therefore, these securities are classified in Level 3 because the Company prices these securities through an internal analysis of each investment's financial statements and cash flow projections. Significant unobservable inputs consist of earnings and revenue multiples, discount for lack of marketability and comparability adjustments. An increase or decrease in any of these unobservable inputs would result in a change in the fair value measurement, which may be significant. The Company did not have any Level 3 equity securities as of December 31, 2017.

*Derivative Financial Instruments* - The fair values of derivative financial instruments are determined using quoted prices in markets that are not active or inputs that are observable for the asset or liability and therefore they are classified as Level 2 in the fair value hierarchy. The fair value of these instruments are recorded in other current assets or accrued expenses, as applicable. The Company did not have any material outstanding derivative financial instruments as of December 31, 2018.

Financial assets and liabilities measured at fair value on a recurring basis on the consolidated balance sheets at December 31, 2018 and 2017 were as follows:

<u><i>In millions</i></u>	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
<b>December 31, 2018</b>				
Assets:				
Debt securities:				
U.S. government securities	\$ 1,597	\$ 91	\$ —	\$ 1,688
States, municipalities and political subdivisions	—	2,399	—	2,399
U.S. corporate securities	—	6,422	67	6,489
Foreign securities	—	2,380	3	2,383
Residential mortgage-backed securities	—	577	—	577
Commercial mortgage-backed securities	—	605	—	605
Other asset-backed securities	—	1,085	—	1,085
Redeemable preferred securities	—	22	7	29
Total debt securities	1,597	13,581	77	15,255
Equity securities	19	—	54	73
Total	\$ 1,616	\$ 13,581	\$ 131	\$ 15,328
<b>December 31, 2017</b>				
Assets:				
Debt securities:				
U.S. corporate securities	\$ —	\$ 1	\$ —	\$ 1
Foreign securities	—	110	—	110
Total debt securities	—	111	—	111
Equity securities	—	—	—	—
Derivative financial instruments	—	5	—	5
Total assets	\$ —	\$ 116	\$ —	\$ 116
Liabilities:				
Derivative financial instruments	\$ —	\$ 23	\$ —	\$ 23

There were no transfers between Levels 1 and 2 during the years ended December 31, 2018 and 2017. The change in the balance of Level 3 financial assets during 2018 relates to investments acquired in the Aetna Acquisition, which occurred on November 28, 2018. There were no transfers into or out of Level 3 from November 28, 2018 to December 31, 2018.

### ***Financial Instruments Not Measured at Fair Value on the Consolidated Balance Sheets***

The carrying value and estimated fair value classified by level of fair value hierarchy for financial instruments carried on the consolidated balance sheets at adjusted cost or contract value at December 31, 2018 and 2017 were as follows:

<b><i>In millions</i></b>	<b>Carrying Value</b>	<b>Estimated Fair Value</b>			<b>Total</b>
		<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>	
<b>December 31, 2018</b>					
Assets:					
Mortgage loans	\$ 1,361	\$ —	\$ —	\$ 1,366	\$ 1,366
Equity securities <sup>(1)</sup>	140	N/A	N/A	N/A	N/A
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	5	—	—	5	5
Without a fixed maturity	382	—	—	357	357
Long-term debt	72,709	71,252	—	—	71,252

<b><i>In millions</i></b>	<b>Carrying Value</b>	<b>Estimated Fair Value</b>			<b>Total</b>
		<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>	
<b>December 31, 2017</b>					
Assets:					
Equity securities <sup>(1)</sup>	\$ 47	N/A	N/A	N/A	N/A
Liabilities:					
Long-term debt	25,726	26,756	—	—	26,756

(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***

As part of the Aetna Acquisition, the Company acquired Separate Accounts assets related to 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 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 as of December 31, 2018 were as follows:

<i>In millions</i>	Level 1	Level 2	Level 3	Total
Debt securities	\$ 782	\$ 2,500	\$ 4	\$ 3,286
Equity securities	—	3	—	3
Common/collective trusts	—	404	—	404
Total <sup>(1)</sup>	\$ 782	\$ 2,907	\$ 4	\$ 3,693

(1) Excludes \$191 million of cash and cash equivalents and accounts receivable at December 31, 2018.

During 2018, the Company had an immaterial amount of Level 3 Separate Accounts financial assets and an immaterial amount of gross transfers of Separate Accounts financial assets into or out of Level 3. During 2018, there were no transfers of Separate Accounts financial assets between Levels 1 and 2. The Company held no Separate Accounts financial assets as of December 31, 2017.

### ***Offsetting Financial Assets and Liabilities***

Subsequent to the Aetna Acquisition Date, 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, including derivative assets, subject to offsetting and enforceable master netting arrangements were \$13 million as of December 31, 2018.

## **5. Goodwill and Other Intangibles**

### ***Goodwill***

Below is a summary of the changes in the carrying amount of goodwill by segment for the years ended December 31, 2018 and 2017:

<i>In millions</i>	Pharmacy Services	Retail/LTC	Health Care Benefits	Total
Balance at December 31, 2016	\$ 21,637	\$ 16,612	\$ —	\$ 38,249
Acquisitions	182	203	—	385
Foreign currency translation adjustments	—	(2)	—	(2)
Impairments	—	(181)	—	(181)
Balance at December 31, 2017	21,819	16,632	—	38,451
Acquisitions	1,569	735	44,484	46,788
Foreign currency translation adjustments	—	(14)	—	(14)
Divestiture of RxCrossroads subsidiary	—	(398)	—	(398)
Impairments	—	(6,149)	—	(6,149)
Balance at December 31, 2018	\$ 23,388	\$ 10,806	\$ 44,484	\$ 78,678

Cumulative goodwill impairments as of December 31, 2018 and 2017 were \$6.1 billion and \$181 million, respectively.

The changes in the carrying amount of goodwill during the years ended December 31, 2018 and 2017 reflect the following activity:

### ***Aetna Acquisition***

On November 28, 2018, the Company completed the Aetna Acquisition. The majority of the preliminary valuation of goodwill associated with the Aetna Acquisition was recorded in the Health Care Benefits segment. The Company also allocated a portion of such goodwill to the Retail/LTC and Pharmacy Services segments related to the fair value of identified synergies that are expected to directly benefit those segments. See Note 2 "Acquisition of Aetna" for further discussion regarding the Aetna Acquisition.

## *LTC*

During 2018, the LTC reporting unit continued 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 and when the 2017 annual goodwill impairment test was performed. These challenges include lower client retention rates, lower occupancy rates in skilled nursing facilities, the deteriorating financial health of numerous skilled nursing facility customers which resulted in a number of customer bankruptcies in 2018, and continued facility reimbursement pressures. In June 2018, LTC management submitted its initial budget for 2019 and updated the 2018 annual forecast which showed a projected deterioration in the financial results for the remainder of 2018 and in 2019, which also caused management to update its long-term forecast beyond 2019. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be impaired and, accordingly, management performed an interim goodwill impairment test as of June 30, 2018. The results of that interim impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in a \$3.9 billion pre-tax goodwill impairment charge in the second quarter of 2018. The fair value of the LTC reporting unit was determined using a combination of a discounted cash flow method and a market multiple method. In addition to the lower financial projections, higher risk-free interest rates and lower market multiples of peer group companies contributed to the amount of the second quarter 2018 goodwill impairment charge.

During the third quarter of 2018, the Company performed its required annual impairment tests of goodwill and concluded there was no impairment of goodwill or trade names.

During the fourth quarter of 2018, the LTC reporting unit missed its forecast primarily due to operational issues and customer liquidity issues, including one significant customer bankruptcy. Additionally, LTC management submitted an updated final budget for 2019 which showed significant additional deterioration in the projected financial results for 2019 compared to the analyses performed in the second and third quarters of 2018 primarily due to continued industry and operational challenges, which also caused management to make further updates to its long-term forecast beyond 2019. The updated projections continue to reflect industry wide challenges including lower occupancy rates in skilled nursing facilities, significant deterioration in the financial health of numerous skilled nursing facility customers and continued facility reimbursement pressures. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be further impaired and, accordingly, an interim goodwill impairment test was performed during the fourth quarter of 2018. The results of that 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 goodwill impairment charge in the fourth quarter of 2018. In addition to the lower financial projections, lower market multiples of peer group companies also contributed to the amount of the fourth quarter 2018 goodwill impairment charge. The fair value of the LTC reporting unit was determined using a methodology consistent with the methodology described above for the analyses performed during the second and third quarters of 2018.

As of December 31, 2018, the remaining goodwill balance in the LTC reporting unit is approximately \$431 million.

## *RxCrossroads*

During 2017, the Company began pursuing various strategic alternatives for its RxCrossroads reporting unit. In connection with this effort, the Company performed an interim goodwill impairment test in the second quarter of 2017. The results of that impairment test showed that the fair value of the RxCrossroads reporting unit was lower than the carrying value, resulting in a \$135 million pre-tax goodwill impairment charge in the second quarter of 2017.

The TCJA was enacted on December 22, 2017 and reduced the United States federal corporate income tax rate from 35% to 21% effective January 1, 2018 (see Note 10 "Income Taxes"). As a result, the RxCrossroads deferred income tax liabilities were reduced by \$47 million and an income tax benefit of \$47 million was recorded in the 2017 statement of operations. The reduction in the deferred income tax liabilities increased the carrying value of the RxCrossroads reporting unit by \$47 million which triggered an additional goodwill impairment charge in the RxCrossroads reporting unit of \$46 million during the fourth quarter of 2017.

On January 2, 2018, the Company sold its RxCrossroads subsidiary to McKesson Corporation for \$725 million, at which time the remaining goodwill of this reporting unit was removed from the consolidated balance sheet.

## Intangible Assets

The following table is a summary of the Company's intangible assets as of December 31:

<i><u>In millions, except weighted average life</u></i>	<b>Gross Carrying Amount</b>	<b>Accumulated Amortization</b>	<b>Net Carrying Amount</b>	<b>Weighted Average Life (years)</b>
<b>2018</b>				
Trademarks (indefinitely-lived)	\$ 10,498	\$ —	\$ 10,498	N/A
Customer contracts/relationships and covenants not to compete	26,213	(6,349)	19,864	14.8
Technology	1,060	(31)	1,029	3.0
Provider networks	4,200	(19)	4,181	20.0
Value of Business Acquired	590	(7)	583	20.0
Favorable leases and other	1,177	(808)	369	17.1
Total	<u>\$ 43,738</u>	<u>\$ (7,214)</u>	<u>\$ 36,524</u>	<u>15.3</u>
<b>2017</b>				
Trademark (indefinitely-lived)	\$ 6,398	\$ —	\$ 6,398	N/A
Customer contracts/relationships and covenants not to compete	12,341	(5,536)	6,805	15.3
Favorable leases and other	1,190	(763)	427	16.2
Total	<u>\$ 19,929</u>	<u>\$ (6,299)</u>	<u>\$ 13,630</u>	<u>15.4</u>

Amortization expense for intangible assets totaled \$1.0 billion, \$817 million and \$795 million for the years ended December 31, 2018, 2017 and 2016, respectively. The projected annual amortization expense for the Company's intangible assets for the next five years is as follows:

<i><u>In millions</u></i>	
2019	\$ 2,563
2020	2,350
2021	2,253
2022	1,879
2023	1,844

## 6. Leases

The Company leases most of its retail and mail order dispensing pharmacy locations, and certain distribution centers and corporate offices under noncancelable operating leases, typically with initial terms of 15 to 25 years and with options that permit renewals for additional periods. The Company also leases certain equipment and other assets under noncancelable operating leases, typically with initial terms of 3 to 10 years.

In December 2015, in connection with the acquisition of the pharmacy and clinic businesses of Target, the Company entered into lease agreements with Target for the pharmacy and clinic space within Target stores. Given that the noncancelable contractual term of the pharmacy lease arrangement exceeds the remaining estimated economic life of the buildings being leased, the Company concluded for accounting purposes that the lease term was the remaining economic life of the buildings. Consequently, most of the individual Target pharmacy and clinic leases are capital leases.

Minimum rent on operating leases is expensed on a straight-line basis over the term of the lease. In addition to minimum rental payments, certain 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.

The following table is a summary of the Company's net rental expense for operating leases for the years ended December 31:

<i><u>In millions</u></i>	<b>2018</b>	<b>2017</b>	<b>2016</b>
Minimum rentals	\$ 2,528	\$ 2,455	\$ 2,418
Contingent rentals	28	29	35
Rental expense	2,556	2,484	2,453
Less: sublease income	(21)	(24)	(24)
Total rental expense, net	<u>\$ 2,535</u>	<u>\$ 2,460</u>	<u>\$ 2,429</u>

The following table is a summary of the future minimum lease payments under capital and operating leases as of December 31, 2018:

<i><u>In millions</u></i>	<b>Capital Leases</b>	<b>Operating Leases<sup>(1)</sup></b>
2019	\$ 74	\$ 2,690
2020	73	2,544
2021	73	2,399
2022	73	2,233
2023	73	2,110
Thereafter	875	16,004
Total future lease payments <sup>(2)</sup>	<u>1,241</u>	<u>\$ 27,980</u>
Less: imputed interest	(599)	
Present value of capital lease obligations	<u>\$ 642</u>	

(1) Future operating lease payments have not been reduced by minimum sublease rentals of \$164 million due in the future under noncancelable subleases.

(2) The Company leases pharmacy and clinic space from Target. Amounts related to such capital and operating leases are reflected above. Amounts due in excess of the remaining estimated economic life of the buildings of approximately \$2.1 billion are not reflected herein since the estimated economic life of the buildings is shorter than the contractual term of the lease arrangement.

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 above table. The Company does not have any retained or contingent interests in the stores and does not provide any guarantees, other than a guarantee of lease payments, in connection with the sale-leaseback transactions. There were no sale-leaseback transactions in 2018. Proceeds from sale-leaseback transactions totaled \$265 million and \$230 million in 2017 and 2016, respectively.

## 7. Health Care Costs Payable

On November 28, 2018, the Company completed the Aetna Acquisition. Prior to the Aetna Acquisition, the Company's health care costs payable balance was immaterial and related to unpaid pharmacy claims for its stand-alone Medicare Part D PDPs within the Pharmacy Services segment. Accordingly, the Company will include disclosures for health care costs payable for the year ended December 31, 2018. Since the health care costs payable liability related to the Pharmacy Services segment is immaterial, the Company's disclosures will be presented on a consolidated basis and will not be disaggregated between the Pharmacy Services and Health Care Benefits segments.

Health care costs payable consist principally of unpaid fee-for-service medical, dental and pharmacy claims, capitation costs, other amounts due to health care providers pursuant to risk-sharing arrangements and accruals for state assessments within the Health Care Benefits segment. 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 was not included in the disclosures included below.

The following table shows the components of the change in health care costs payable during 2018:

***In millions***

Health care costs payable, beginning of the period	\$ 5
Less: Reinsurance recoverables	—
Health care costs payable, beginning of the period, net	<u>5</u>
Acquisitions, net	<u>5,357</u>
Add: Components of incurred health care costs	
Current year	6,594
Prior years	<u>(42)</u>
Total incurred health care costs <sup>(1)</sup>	<u>6,552</u>
Less: Claims paid	
Current year	6,464
Prior years	<u>260</u>
Total claims paid	<u>6,724</u>
Add: Premium deficiency reserve	<u>16</u>
Health care costs payable, end of period, net	5,206
Add: Reinsurance recoverables	<u>4</u>
Health care costs payable, end of period	<u><u>\$ 5,210</u></u>

(1) Total incurred health care costs for the year ended December 31, 2018 in the table above exclude (i) \$16 million related to a premium deficiency reserve for the 2019 coverage year related to Medicaid products, (ii) \$4 million of benefit costs recorded in the Health Care Benefits segment that are included in Other Insurance Liabilities on the consolidated balance sheet and (iii) \$22 million of benefit costs recorded in the Corporate/Other segment that are included in Other Insurance Liabilities on the consolidated balance sheet.

At December 31, 2018, the Company's liabilities for IBNR plus expected development on reported claims totaled approximately \$4.1 billion. Substantially all of the Company's liabilities for IBNR plus expected development on reported claims at December 31, 2018 related to the current calendar year.

Due to the proximity of the Aetna Acquisition Date to December 31, 2018, the Company did not include disclosures related to incurred and paid claim development from November 28, 2018 to December 31, 2018. The Company will begin including disclosures related to incurred and paid claim development for the year ended December 31, 2019.

## 8. Borrowings and Credit Agreements

The following table is a summary of the Company's borrowings as of December 31:

<u>In millions</u>	<u>2018</u>	<u>2017</u>
<u>Short-term debt</u>		
Commercial paper	\$ 720	\$ 1,276
<u>Long-term debt</u>		
1.9% senior notes due July 2018	—	2,250
2.25% senior notes due December 2018	—	1,250
2.2% senior notes due March 2019	375	—
2.25% senior notes due August 2019	850	850
3.125% senior notes due March 2020	2,000	—
Floating rate notes due March 2020	1,000	—
2.8% senior notes due July 2020	2,750	2,750
3.35% senior notes due March 2021	3,000	—
Floating rate notes due March 2021	1,000	—
4.125% senior notes due May 2021	550	550
2.125% senior notes due June 2021	1,750	1,750
4.125% senior notes due June 2021	500	—
5.45% senior notes due June 2021	600	—
3-Year tranche loan due November 2021	3,000	—
3.5% senior notes due July 2022	1,500	1,500
2.75% senior notes due November 2022	1,000	—
2.75% senior notes due December 2022	1,250	1,250
4.75% senior notes due December 2022	399	399
3.7% senior notes due March 2023	6,000	—
2.8% senior notes due June 2023	1,300	—
4% senior notes due December 2023	1,250	1,250
3.375% senior notes due August 2024	650	650
3.5% senior notes due November 2024	750	—
5% senior notes due December 2024	299	299
4.1% senior notes due March 2025	5,000	—
3.875% senior notes due July 2025	2,828	2,828
2.875% senior notes due June 2026	1,750	1,750
6.25% senior notes due June 2027	372	372
4.3% senior notes due March 2028	9,000	—
4.875% senior notes due July 2035	652	652
3.25% senior exchange debentures due December 2035	—	1
6.625% senior notes due June 2036	771	—
6.75% senior notes due December 2037	533	—
4.78% senior notes due March 2038	5,000	—
6.125% senior notes due September 2039	447	447
5.75% senior notes due May 2041	133	133
4.5% senior notes due May 2042	500	—
4.125% senior notes due November 2042	500	—
5.3% senior notes due December 2043	750	750
4.75% senior notes due March 2044	375	—
5.125% senior notes due July 2045	3,500	3,500
3.875% senior notes due August 2047	1,000	—
5.05% senior notes due March 2048	8,000	—
Capital lease obligations	642	670
Other	19	43
Total debt principal	74,265	27,170
Debt premiums	302	28
Debt discounts and deferred financing costs	(1,138)	(196)
	73,429	27,002
Less:		
Short-term debt (commercial paper)	(720)	(1,276)
Current portion of long-term debt	(1,265)	(3,545)
Long-term debt	<u>\$ 71,444</u>	<u>\$ 22,181</u>

The following is a summary of the Company's required principal debt repayments due during each of the next five years and thereafter, as of December 31, 2018:

***In millions***

2019	\$ 1,985
2020	5,775
2021	10,427
2022	4,178
2023	8,581
Thereafter	43,319
<b>Total</b>	<b>\$ 74,265</b>

***Short-term Borrowings***

*Commercial Paper and Back-up Credit Facilities*

The Company had approximately \$720 million and \$1.3 billion of commercial paper outstanding at weighted average interest rates of 2.8% and 2.0% as of December 31, 2018 and 2017, respectively. In connection with its commercial paper program, the Company maintains a \$1.75 billion 364-day unsecured back-up revolving credit facility, which expires on May 16, 2019, a \$1.25 billion, five-year unsecured back-up revolving credit facility, which expires on July 1, 2020, a \$1.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 18, 2022, and a \$2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 17, 2023. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately .03%, regardless of usage. As of December 31, 2018 and 2017, there were no borrowings outstanding under any of the back-up credit facilities.

*Bridge Loan Facility*

On December 3, 2017, in connection with the Aetna Acquisition, the Company entered into a \$49.0 billion unsecured bridge loan facility commitment. The Company paid \$221 million in fees upon entering into the agreement. The fees were capitalized in other current assets and were amortized as interest expense over the period the bridge loan facility commitment was outstanding. The bridge loan facility commitment was reduced to \$44.0 billion on December 15, 2017 upon the Company entering into a \$5.0 billion term loan agreement. The Company recorded \$56 million of amortization of the bridge loan facility fees during the year ended December 31, 2017, which was recorded in interest expense in the consolidated statements of operations.

On March 9, 2018, the Company issued an aggregate of \$40.0 billion principal amount of unsecured floating rate notes and unsecured fixed rate senior notes, collectively the "2018 Notes". At this time, the bridge loan facility commitment was reduced to \$4.0 billion, and the Company paid \$8 million in fees to retain the bridge loan facility commitment through the Aetna Acquisition Date. Those fees were capitalized in other current assets and were amortized as interest expense over the period the bridge loan facility commitment was outstanding. The Company recorded \$173 million of amortization of the bridge loan facility commitment fees during the year ended December 31, 2018, which was recorded in interest expense in the consolidated statement of operations. On October 26, 2018, the Company entered into a \$4.0 billion unsecured 364-day bridge term loan agreement to formalize the bridge loan facility discussed above. On November 28, 2018, in connection with the Aetna Acquisition, the \$4.0 billion unsecured 364-day bridge term loan agreement terminated.

*Terminated Revolving Credit Facility*

On January 3, 2017, the Company entered into a \$2.5 billion revolving credit facility. The credit facility allowed for borrowings at various rates that were dependent, in part, on the Company's debt ratings and required the Company to pay a weighted average quarterly facility fee of approximately 0.03%, regardless of usage. The Company terminated this credit facility in May 2017.

*Federal Home Loan Bank of Boston*

Since the Aetna Acquisition Date, a subsidiary of the Company is a member of the FHLBB. As a member, the subsidiary has the ability to obtain cash advances, subject to certain minimum collateral requirements. The maximum borrowing capacity available from the FHLBB as of December 31, 2018 was approximately \$790 million. As of December 31, 2018, there were no outstanding advances from the FHLBB.

## ***Long-term Borrowings***

### *2018 Notes*

On March 9, 2018, the Company issued the 2018 Notes with an aggregate principal amount of \$40.0 billion, for total proceeds of approximately \$39.4 billion, net of discounts and underwriting fees. The net proceeds of the 2018 Notes were used to fund a portion of the Aetna Acquisition. The 2018 Notes are comprised of the following:

### ***In millions***

3.125% senior notes due March 2020	\$ 2,000
Floating rate notes due March 2020	1,000
3.35% senior notes due March 2021	3,000
Floating rate notes due March 2021	1,000
3.7% senior notes due March 2023	6,000
4.1% senior notes due March 2025	5,000
4.3% senior notes due March 2028	9,000
4.78% senior notes due March 2038	5,000
5.05% senior notes due March 2048	8,000
Total debt principal	<u>\$ 40,000</u>

Beginning in December 2017 through March 31, 2018, the Company entered into several interest rate swap and treasury lock transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of long-term debt to fund the Aetna Acquisition.

In connection with the issuance of the 2018 Notes, the Company terminated all outstanding cash flow hedges. In connection with the hedge transactions, the Company received a net amount of \$446 million from the hedge counterparties upon termination, which was recorded as a gain, net of tax, of \$331 million in accumulated other comprehensive income and will be reclassified as a reduction of interest expense over the life of the 2018 Notes. See Note 13 “Other Comprehensive Income (Loss)” for additional information. The Company expects to reclassify approximately \$18 million, net of tax, in gains associated with these cash flow hedges into net income within the next 12 months.

### *Term Loan Agreement*

On December 15, 2017, in connection with the Aetna Acquisition, the Company entered into a \$5.0 billion term loan agreement. The term loan facility under the term loan agreement consists of a \$3.0 billion three-year tranche and a \$2.0 billion five-year tranche. The term loan agreement allows for borrowings at various rates that are dependent, in part, on the Company’s debt ratings. In connection with the Aetna Acquisition, the Company borrowed \$5.0 billion (a \$3.0 billion three-year tranche and a \$2.0 billion five-year tranche) under term loan agreement in November 2018. The Company terminated the \$2.0 billion five-year tranche in December 2018 with the repayment of the borrowing. As of December 31, 2018, the Company had \$3.0 billion outstanding under the three-year tranche of the term loan agreement.

### *Aetna Related Debt*

On the Aetna Acquisition Date, the Company assumed long-term debt with a fair value of \$8.1 billion, with stated interest rates ranging from 2.2% to 6.75%. The long-term debt assumed is included in the summary of borrowings table above.

### *2016 Notes*

On May 16, 2016, the Company issued \$1.75 billion aggregate principal amount of 2.125% unsecured senior notes due June 1, 2021 and \$1.75 billion aggregate principal amount of 2.875% unsecured senior notes due June 1, 2026 (collectively, the “2016 Notes”) for total proceeds of approximately \$3.5 billion, net of discounts and underwriting fees. The 2016 Notes may be redeemed, in whole at any time, or in part from time to time, at the Company’s option at a defined redemption price plus accrued and unpaid interest to the redemption date. The net proceeds of the 2016 Notes were used for general corporate purposes and to repay certain corporate debt.

### *Early Extinguishment of Long-Term Debt*

On May 16, 2016, the Company announced tender offers for (i) any and all of its 5.75% senior notes due 2017, its 6.60% senior notes due 2019 and its 4.75% senior notes due 2020 (collectively, the “Any and All Notes”) and (ii) up to \$1.5 billion aggregate

principal amount of the 4.75% Senior Notes due 2022 issued by its wholly-owned subsidiary Omnicare, the 5.00% Senior Notes due 2024 issued by Omnicare, its 3.875% Senior Notes due 2025, its 6.25% Senior Notes due 2027, its 4.875% Senior Notes due 2035, its 6.125% Senior Notes due 2039 and its 5.75% Senior Notes due 2041 (collectively, the “Maximum Tender Offer Notes” and together with the Any and All Notes, the “Notes”). On May 31, 2016, the Company increased the aggregate principal amount of the tender offers for the Maximum Tender Offer Notes to \$2.25 billion. The Company purchased approximately \$835 million aggregate principal amount of the Any and All Notes and \$2.25 billion aggregate principal amount of the Maximum Tender Offer Notes pursuant to the tender offers, which expired on June 13, 2016. In connection with the purchase of the Notes, the Company paid a premium of \$486 million in excess of the debt principal, wrote off \$50 million of unamortized deferred financing costs and incurred \$6 million in fees, for a total loss on early extinguishment of long-term debt of \$542 million, which was recorded in income from continuing operations in the consolidated statement of operations for the year ended December 31, 2016.

On June 27, 2016, the Company notified the holders of the remaining Any and All Notes that the Company was exercising its option to redeem the outstanding Any and All Notes pursuant to the terms of the Any and All Notes and the Indenture dated as of August 15, 2006, between the Company and The Bank of New York Mellon Trust Company, N.A. Approximately \$1.1 billion aggregate principal amount of Any and All Notes was redeemed on July 27, 2016. In connection with that redemption, the Company paid a premium of \$97 million in excess of the debt principal and wrote off \$4 million of unamortized deferred financing costs, for a total loss on early extinguishment of long-term debt of \$101 million, which was recorded in income from continuing operations in the consolidated statement of operations for the year ended December 31, 2016.

### ***Debt Covenants***

The back-up revolving credit facilities, unsecured senior notes, unsecured floating rate notes and term loan agreement contain customary restrictive financial and operating covenants. These covenants do not include a requirement for the acceleration of the Company’s debt maturities in the event of a downgrade in the Company’s credit rating. The Company does not believe the restrictions contained in these covenants materially affect its financial or operating flexibility. As of December 31, 2018, 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, 2018, 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 without restriction among various investment options under each plan. Two of the defined contribution plans offer the Company’s common stock fund as an investment option. The Company also maintains nonqualified, unfunded deferred compensation plans for certain key employees. The plans provide participants the opportunity to defer portions of their eligible compensation and for certain nonqualified plans, participants receive matching contributions equivalent to what they could have received under the CVS Health 401(k) Plan or Aetna 401(k) Plan absent certain restrictions and limitations under the Internal Revenue Code. The Company’s contributions under the above defined contribution plans were \$334 million, \$314 million and \$295 million in 2018, 2017 and 2016, respectively. The Company’s contributions for the year ended December 31, 2018 include contributions to the Aetna Inc. 401(k) plan subsequent to the Aetna Acquisition Date.

### ***Defined Benefit Pension Plans***

On November 28, 2018, the Company completed the Aetna Acquisition. Aetna sponsors a tax-qualified pension plan that was frozen in 2010. Aetna also sponsors a non-qualified supplemental pension plan that was frozen in 2007. Aetna’s pension plan benefit obligations and the fair value of plan assets were remeasured as of the Aetna Acquisition Date.

Prior to the Aetna Acquisition, during the year ended December 31, 2017, the Company settled the pension obligations of its existing two tax-qualified defined benefit pension plans by irrevocably transferring pension liabilities to an insurance company through the purchase of group annuity contracts and through lump sum distributions. These purchases, funded with pension plan assets, resulted in pre-tax settlement losses of \$187 million in the year ended December 31, 2017, related to the recognition of accumulated deferred actuarial losses. The settlement losses were recorded in other expense in the consolidated statement of operations. The Company also sponsors several other defined benefit pension plans that are unfunded nonqualified supplemental retirement plans as described in the “Other Postretirement Benefits” section below.

*Pension Benefit Obligations and Plan Assets*

The following tables outline the change in benefit obligations and plan assets over the specified periods:

<b><i>In millions</i></b>	<b>2018</b>	<b>2017</b>
Change in benefit obligation:		
Benefit obligation, beginning of year	\$ 131	\$ 844
Acquired benefit obligations	5,685	—
Interest cost	25	20
Actuarial loss (gain)	41	(31)
Benefit payments	(41)	(35)
Settlements	—	(667)
Benefit obligation, end of year	<u>\$ 5,841</u>	<u>\$ 131</u>

<b><i>In millions</i></b>	<b>2018</b>	<b>2017</b>
Change in plan assets:		
Fair value of plan assets, beginning of year	\$ —	\$ 624
Fair value of plan assets acquired	5,709	—
Actual return on plan assets	(17)	32
Employer contributions	12	46
Benefit payments	(41)	(35)
Settlements	—	(667)
Fair value of plan assets, end of year	<u>5,663</u>	<u>—</u>
Funded status	<u>\$ (178)</u>	<u>\$ (131)</u>

The assets (liabilities) recognized on the consolidated balance sheets at December 31, 2018 and 2017 for the pension plans consisted of the following:

<b><i>In millions</i></b>	<b>2018</b>	<b>2017</b>
Accrued benefit assets reflected in other assets	\$ 147	\$ —
Accrued benefit liabilities reflected in accrued expenses	(25)	(21)
Accrued benefit liabilities reflected in other long-term liabilities	(300)	(110)
Net liabilities	<u>\$ (178)</u>	<u>\$ (131)</u>

*Net Periodic Benefit Costs*

The components of net periodic benefit cost for the years ended December 31 are shown below:

<b><i>In millions</i></b>	<b>2018</b>	<b>2017</b>	<b>2016</b>
Components of net periodic benefit cost:			
Interest cost	\$ 25	\$ 20	\$ 27
Expected return on plan assets	(33)	(20)	(32)
Amortization of net actuarial loss	2	21	32
Settlement losses	—	187	—
Net periodic benefit cost	<u>\$ (6)</u>	<u>\$ 208</u>	<u>\$ 27</u>

### *Pension Plan Assumptions*

The Company uses a series of actuarial assumptions to determine its benefit obligations and net benefit costs as further detailed below.

**Discount Rates** - The discount rate for the acquired Aetna plans is determined using a yield curve as of the annual measurement date. Each yield curve consisted 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. The weighted average discount rate for the Aetna pension plans was 4.4% in 2018.

The Company settled the pension obligations of its existing tax-qualified plans during 2017. The discount rates for determining plan benefit obligations (excluding the terminated qualified plan) were approximately 4.0%, 3.5% and 4.0% in 2018, 2017 and 2016, respectively. The discount rate for the terminated qualified plan was 3.1% in 2016.

**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. The expected long-term rate of return for the acquired Aetna plans was 6.6% in 2018. See "Pension Plan Assets" below for additional details regarding the Aetna pension plan assets as of December 31, 2018.

The Company settled the pension obligations of its existing tax-qualified plans during 2017. The expected long-term rate of return for these plans ranged from 4.0% to 5.5% in both 2017 and 2016.

**Net Actuarial Losses/Gains** - Based on the mortality experience of the acquired Aetna pension plans, in 2018 the Company utilized the RP-2014WC Mortality Table with a generation projection of future mortality improvements using Scale MP-2018 for the acquired Aetna plans.

### *Pension Plan Assets*

As of December 31, 2017, the assets in the Company's prior qualified defined benefit pension plans had been fully liquidated to settle all plan obligations through the purchase of group annuity contracts and through lump sum distributions. On November 28, 2018, the Company completed the Aetna Acquisition. At December 31, 2018, the assets of the Aetna pension plan (the "Aetna Pension Plan") primarily include debt and equity securities held in separate accounts, as well as common/collective trusts and real estate investments. The valuation methodologies used to price these debt and equity securities and common/collective trusts are similar to the methodologies described in Note 4 "Fair Value." Assets of the Aetna pension plan also include investments in other assets that are carried at fair value. The following is a description of the valuation methodology used to price 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 includes, 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.

Aetna Pension Plan assets with changes in fair value measured on a recurring basis at December 31, 2018 were as follows:

<i>In millions</i>	Level 1	Level 2	Level 3	Total
<b>Debt securities:</b>				
U.S. government securities	\$ 511	\$ 38	\$ —	\$ 549
States, municipalities and political subdivisions	—	147	—	147
U.S. corporate securities	—	1,671	5	1,676
Foreign securities	—	177	—	177
Residential mortgage-backed securities	—	339	—	339
Commercial mortgage-backed securities	—	70	—	70
Other asset-backed securities	—	162	—	162
Redeemable preferred securities	—	6	—	6
<b>Total debt securities</b>	<b>511</b>	<b>2,610</b>	<b>5</b>	<b>3,126</b>
<b>Equity securities:</b>				
U.S. Domestic	744	—	—	744
International	356	—	—	356
Domestic real estate	30	—	—	30
<b>Total equity securities</b>	<b>1,130</b>	<b>—</b>	<b>—</b>	<b>1,130</b>
<b>Other investments:</b>				
Real estate	—	—	425	425
Common/collective trusts <sup>(1)</sup>	—	253	—	253
Derivatives	—	2	—	2
<b>Total other investments</b>	<b>—</b>	<b>255</b>	<b>425</b>	<b>680</b>
<b>Total pension investments <sup>(2)</sup></b>	<b>\$ 1,641</b>	<b>\$ 2,865</b>	<b>\$ 430</b>	<b>\$ 4,936</b>

(1) The assets in the underlying funds of common/collective trusts consist of \$109 million of equity securities and \$144 million of debt securities.

(2) Excludes \$98 million of cash and cash equivalents, \$465 million of private equity limited partnership investments and \$164 million of hedge fund limited partnership investments as the amounts are carried at fair value.

The change in the balance of pension plan assets during 2018 relates to investments acquired in the Aetna Acquisition, which occurred on November 28, 2018. There was an immaterial amount of transfers into or out of Level 3 from November 28, 2018 to December 31, 2018.

The Aetna Pension Plan invests in a diversified mix of assets intended to maximize long-term returns while recognizing the need for adequate liquidity to meet ongoing benefit and administrative obligations. The risk of unexpected investment and actuarial outcomes is regularly evaluated. This evaluation is performed through forecasting and assessing ranges of investment outcomes over short- and long-term horizons and by assessing Aetna Pension Plan's liability characteristics. Complementary investment styles and techniques are utilized by multiple professional investment 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, 2018, target investment allocations for the Aetna Pension Plan were: 31% in equity securities, 57% in 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 Aetna Pension Plan's Benefit Finance Committee. Forecasting of asset and liability growth is performed at least annually.

### *Cash Flows*

The Company generally contributes to its tax-qualified pension plans based on minimum funding requirements determined under applicable federal laws and regulations. Employer contributions related to the non-qualified supplemental pension plans generally represent payments to retirees for current benefits. The Company contributed \$12 million, \$46 million and \$25 million to the pension plans during 2018, 2017 and 2016, respectively. No contributions are required for the Aetna Pension Plan in 2019. The Company expects to make an immaterial amount of contributions for all other pension plans in 2019. The Company estimates the following future benefit payments, which are calculated using the same actuarial assumptions used to measure the pension plan benefit obligation as of December 31, 2018:

<b><i>In millions</i></b>	
2019	\$ 375
2020	387
2021	411
2022	387
2023	391
2024-2028	1,916

### *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 aspects: (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, referred to as a withdrawal liability.

None of the multiemployer pension plans in which the Company participates are individually significant to the Company. Total Company contributions to multiemployer pension plans were \$18 million, \$17 million and \$15 million in 2018, 2017 and 2016, respectively.

### *Other Postretirement Benefits*

The Company provides postretirement health care and life insurance benefits to certain retirees who meet eligibility requirements. On November 28, 2018, the Company completed the Aetna Acquisition. Aetna also sponsors OPEB plans that provide certain health care and life insurance benefits for retired employees. 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, 2018 and 2017, the Company's other postretirement benefits had an accumulated postretirement benefit obligation of \$228 million and \$25 million, respectively. Net periodic benefit costs related to these other postretirement benefits were \$2 million in 2018, and \$1 million in both 2017 and 2016.

The Company estimates the following future benefit payments, which are calculated using the same actuarial assumptions used to measure the other postretirement benefit obligation as of December 31, 2018:

<b><i>In millions</i></b>	
2019	\$ 17
2020	17
2021	17
2022	16
2023	16
2024-2028	76

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. Total Company contributions to multiemployer health and welfare plans were \$58 million, \$58 million and \$52 million in 2018, 2017 and 2016, respectively.

## 10. Income Taxes

The income tax provision for continuing operations consisted of the following for the years ended December 31:

<u><i>In millions</i></u>	<b>2018</b>	<b>2017</b>	<b>2016</b>
Current:			
Federal	\$ 1,480	\$ 2,594	\$ 2,803
State	499	464	511
	<u>1,979</u>	<u>3,058</u>	<u>3,314</u>
Deferred:			
Federal	22	(1,435)	5
State	1	14	(2)
	<u>23</u>	<u>(1,421)</u>	<u>3</u>
Total	<u>\$ 2,002</u>	<u>\$ 1,637</u>	<u>\$ 3,317</u>

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 noncash income tax benefit of approximately \$1.5 billion for year ended December 31, 2017. The Company completed its assessment of the TCJA's final impact in December 2018 and recorded an additional tax benefit of approximately \$100 million in the year ended December 31, 2018.

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:

	<b>2018</b>	<b>2017</b>	<b>2016</b>
Statutory income tax rate	21.0%	35.0%	35.0%
State income taxes, net of federal tax benefit	27.7	4.1	4.1
Effect of the Tax Cuts and Jobs Act	(7.1)	(18.3)	—
Health insurer fee	2.2	—	0.2
Goodwill impairments	89.5	0.8	—
Sale of subsidiary	5.0	—	—
Other	4.1	(1.8)	(0.9)
Effective income tax rate	<u>142.4%</u>	<u>19.8%</u>	<u>38.4%</u>

The following table is a summary of the components of the Company's deferred income tax assets and liabilities as of December 31:

<i><b>In millions</b></i>	<b>2018</b>	<b>2017</b>
Deferred income tax assets:		
Lease and rents	\$ 277	\$ 291
Inventory	28	31
Employee benefits	243	246
Allowance for doubtful accounts	243	187
Retirement benefits	130	40
Net operating loss and capital loss carryforwards	529	101
Deferred income	104	93
Insurance reserves	467	—
Investments	11	—
Other	242	18
Valuation allowance	(520)	(77)
Total deferred income tax assets	<u>1,754</u>	<u>930</u>
Deferred income tax liabilities:		
Depreciation and amortization	(9,431)	(3,926)
Total deferred income tax liabilities	<u>(9,431)</u>	<u>(3,926)</u>
Net deferred income tax liabilities	<u>\$ (7,677)</u>	<u>\$ (2,996)</u>

The increase in net deferred income tax liabilities is mainly due to the Aetna Acquisition. As of December 31, 2018, the Company has net operating and capital loss carryovers of approximately \$529 million. 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 recent results of operations. The Company established a valuation allowance of \$520 million because it does not consider it more likely than not that these deferred tax assets will be recovered.

A reconciliation of the beginning and ending amount of unrecognized tax benefits is as follows:

<i><b>In millions</b></i>	<b>2018</b>	<b>2017</b>	<b>2016</b>
Beginning balance	\$ 344	\$ 307	\$ 338
Additions based on tax positions related to the current year	1	62	68
Additions based on tax positions related to prior years	324	32	70
Reductions for tax positions of prior years	(5)	(28)	(100)
Expiration of statutes of limitation	(2)	(10)	(22)
Settlements	(1)	(19)	(47)
Ending balance	<u>\$ 661</u>	<u>\$ 344</u>	<u>\$ 307</u>

The increase in the balance of unrecognized tax benefits in 2018 compared to 2017 and 2016 is mainly due to the Aetna Acquisition.

The Company and most of its subsidiaries are subject to United States federal income tax as well as income tax of numerous state and local jurisdictions. The Company is a participant in the Compliance Assurance Process, which is a program made available by the 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 return. The IRS has substantially completed its examinations of the Company's 2015, 2016 and 2017 consolidated United States federal income tax returns. The IRS is currently examining the Company's 2018 consolidated United States federal income tax return.

The Company and its subsidiaries are also currently under income tax examinations by a number of state and local tax authorities. As of December 31, 2018, no examination has resulted in any proposed adjustments that would result in a material change to the Company's results of operations, financial condition or liquidity.

Substantially all material state and local income tax matters have been concluded for fiscal years through 2012. Certain state exams are likely to be concluded and certain state statutes of limitations will lapse in 2019, 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 \$19 million, \$11 million and \$10 million in 2018, 2017 and 2016, respectively. The Company had approximately \$80 million and \$34 million accrued for interest and penalties as of December 31, 2018 and 2017, respectively.

As of December 31, 2018, the total amount of unrecognized tax benefits that, if recognized, would affect the Company's effective income tax rate is approximately \$597 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 the Company's Board of Directors (the "Board"). The ICP allows for a maximum of 32 million shares of CVS Health common stock to be reserved and available for grants. Prior to the acquisition of Aetna in 2018, the ICP was the only compensation plan under which the Company granted stock options, restricted stock and other stock-based awards to its employees, with the exception of the Company's Employee Stock Purchase Plan ("ESPP"). As of December 31, 2018, there were approximately 26 million shares of CVS Health common stock available for future grants under the ICP.

As of the Aetna Acquisition Date, approximately 22 million shares of Aetna common stock subject to awards outstanding under the Amended Aetna Inc. 2010 Stock Incentive Plan ("SIP") were assumed by CVS Health. In addition, in accordance with the merger agreement, shares which were available for future issuance under the SIP were converted into approximately 32 million shares of CVS Health common stock reserved and available for issuance pursuant to future awards. As of December 31, 2018, there were approximately 32 million shares of CVS Health common stock available for future grants under the SIP.

### *Stock-based Compensation Expense*

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as expense over the requisite service period of the stock award (generally three to five years) using the straight-line method. The following table is a summary of stock-based compensation for each of the respective periods:

<u><i>In millions</i></u>	<u>2018</u>	<u>2017</u>	<u>2016</u>
Stock options and stock appreciation rights ("SARs") <sup>(1)(2)</sup>	\$ 70	\$ 65	\$ 79
Restricted stock units and performance stock units <sup>(2)</sup>	210	169	143
Total stock-based compensation	<u>\$ 280</u>	<u>\$ 234</u>	<u>\$ 222</u>

(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 acquisition.

### *ESPP*

The ESPP provides for the purchase of up to 30 million shares of common stock. Under the ESPP, beginning in 2016, eligible employees could 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. Prior to 2016, the purchase price was equal

to 85% of the lower of the fair market value on the first day or the last day of the offering period. During 2018, approximately two million shares of common stock were purchased under the provisions of the ESPP at an average price of \$61.40 per share. As of December 31, 2018, approximately 9 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 each of the respective periods:

	<b>2018</b>	<b>2017</b>	<b>2016</b>
Dividend yield <sup>(1)</sup>	1.45%	1.24%	0.88%
Expected volatility <sup>(2)</sup>	28.02%	22.70%	20.64%
Risk-free interest rate <sup>(3)</sup>	1.87%	0.86%	0.45%
Expected life (in years) <sup>(4)</sup>	0.5	0.5	0.5
Weighted-average grant date fair value	\$ 12.26	\$ 13.01	\$ 14.98

(1) The dividend yield is calculated based on semi-annual dividends paid and the fair market value of the Company's stock at the grant date.

(2) The expected volatility is based on the historical volatility of the Company's daily stock market prices over the previous six month period.

(3) The risk-free interest rate is 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. Vesting of the Company's performance stock units is dependent upon the degree to which the Company achieves its performance goals, which are set at the time of grant by the MP&D Committee. For each restricted stock unit and performance share stock granted, employees receive one share of common stock, net of taxes, at the end of the vesting period. Compensation cost is recorded based on the market price of the Company's common stock on the grant date and is recognized on a straight-line basis over the requisite service 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, 2018, there was \$491 million of total unrecognized compensation cost related to Company 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 2.01 years. The total fair value of restricted shares vested during 2018, 2017 and 2016 was \$262 million, \$175 million and \$218 million, respectively.

The following table is a summary of the restricted stock unit and performance stock unit activity for the year ended December 31, 2018:

<b><u>Units in thousands</u></b>	<b>Units</b>	<b>Weighted Average Grant Date Fair Value</b>
Unvested at beginning of year	5,014	\$ 86.92
Granted	10,185	\$ 73.18
Vested	(3,757)	\$ 68.85
Forfeited	(437)	\$ 76.92
Unvested at end of year	<u>11,005</u>	<u>\$ 76.18</u>

### ***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 generally expire seven 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, 2018, 2017 and 2016:

<i><b>In millions</b></i>	<b>2018</b>	<b>2017</b>	<b>2016</b>
Cash received from stock options exercised (including ESPP)	\$ 242	\$ 329	\$ 296
Payments for taxes for net share settlement of equity awards	97	71	72
Intrinsic value of stock options and SARs exercised	79	176	244
Fair value of stock options and SARs vested	324	341	298

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:

	<b>2018</b>	<b>2017</b>	<b>2016</b>
Dividend yield <sup>(1)</sup>	2.76%	2.56%	1.62%
Expected volatility <sup>(2)</sup>	21.27%	18.39%	17.22%
Risk-free interest rate <sup>(3)</sup>	2.77%	1.77%	1.24%
Expected life (in years) <sup>(4)</sup>	4.8	4.1	4.2
Weighted-average grant date fair value	\$ 24.55	\$ 9.43	\$ 13.00

(1) The dividend yield is based on annual dividends paid and the fair market value of the Company's stock at the grant date.

(2) The expected volatility is estimated using the Company's historical volatility 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 holder exercise experience.

As of December 31, 2018, unrecognized compensation expense related to unvested stock options and SARs totaled \$58 million, which the Company expects to be recognized over a weighted-average period of 1.2 years. After considering anticipated forfeitures, the Company expects approximately 11 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, 2018

<u><i>In thousands, except weighted average exercise price and remaining contractual term</i></u>	<u>Shares</u>	<u>Weighted Average Exercise Price</u>	<u>Weighted Average Remaining Contractual Term</u>	<u>Aggregate Intrinsic Value</u>
Outstanding at December 31, 2017	20,530	\$ 75.32		
Granted	7,144	\$ 51.06		
Exercised	(2,993)	\$ 44.62		
Forfeited	(908)	\$ 86.97		
Expired	(864)	\$ 81.79		
Outstanding at December 31, 2018	<u>22,909</u>	\$ 71.15	4.08	\$ 165,245
Exercisable at December 31, 2018	<u>11,436</u>	\$ 72.69	2.23	\$ 73,784
Vested at December 31, 2018 and expected to vest in the future	22,532	\$ 71.18	4.05	\$ 163,596

## 12. Shareholders' Equity

### *Share Repurchases*

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

<u><i>In billions</i></u>	<u>Authorized</u>	<u>Remaining as of December 31, 2018</u>
<u>Authorization Date</u>		
November 2, 2016 ("2016 Repurchase Program")	\$ 15.0	\$ 13.9
December 15, 2014 ("2014 Repurchase Program")	10.0	—

The share Repurchase Programs, each of which was effective immediately, permit the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase ("ASR") transactions, and/or other derivative transactions. The 2014 Repurchase Program was completed during the second quarter of 2017. The 2016 Repurchase Program can be modified or terminated by the Board at any time.

#### *2018 Activity*

During the year ended December 31, 2018, the Company did not repurchase any shares of common stock pursuant to the 2016 Repurchase Program.

#### *2017 Activity*

Pursuant to the authorization under the 2014 Repurchase Program, in August 2016, the Company entered into two fixed dollar ASRs with Barclays Bank PLC ("Barclays") for a total of \$3.6 billion. Upon payment of the \$3.6 billion purchase price in January 2017, the Company received a number of shares of its common stock equal to 80% of the \$3.6 billion notional amount of the ASRs or approximately 36.1 million shares, which were placed into treasury stock in January 2017. The ASRs were accounted for as an initial treasury stock transaction for \$2.9 billion and a forward contract for \$0.7 billion. In April 2017, the Company received an additional 9.9 million shares of common stock, representing the remaining 20% of the \$3.6 billion notional amount of the ASRs, thereby concluding the ASRs. The additional 9.9 million shares of common stock delivered to the Company by Barclays were placed into treasury stock and the forward contract was reclassified from capital surplus to treasury stock in April 2017.

During the year ended December 31, 2017, the Company repurchased an aggregate of 55.4 million shares of common stock for approximately \$4.4 billion under the 2014 and 2016 Repurchase Programs.

#### *2016 Activity*

Pursuant to the authorization under the 2014 Repurchase Program, in December 2015, the Company entered into a \$725 million fixed dollar ASR with Barclays. Upon payment of the \$725 million purchase price in December 2015, the Company received a number of shares of its common stock equal to 80% of the \$725 million notional amount of the ASR or approximately 6.2

million shares, which were placed into treasury stock in December 2015. The ASR was accounted for as an initial treasury stock transaction for \$580 million and a forward contract for \$145 million. The forward contract was classified as an equity instrument and was recorded within capital surplus on the consolidated balance sheet. In January 2016, the Company received an additional 1.4 million shares of common stock, representing the remaining 20% of the \$725 million notional amount of the ASR, thereby concluding the ASR. The additional 1.4 million shares of common stock delivered to the Company by Barclays were placed into treasury stock and the forward contract was reclassified from capital surplus to treasury stock in January 2016.

During the year ended December 31, 2016, the Company repurchased an aggregate of 47.5 million shares of common stock for approximately \$4.5 billion under the 2014 Repurchase Program.

### ***Dividends***

The quarterly cash dividend declared by the Board was \$0.50 per share in 2018 and 2017. CVS Health has paid cash dividends every quarter since becoming a public company. Future 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 year ended December 31, 2018 (which includes Aetna and its subsidiaries from November 28, 2018 to December 2018) was not material. The combined statutory capital and surplus at December 31, 2018 of the Company's insurance and HMO subsidiaries was approximately \$11.1 billion. From November 28, 2018 to December 31, 2018, the Company's insurance and HMO subsidiaries paid \$909 million of gross dividends to the Company.

In addition to general state law restrictions on payments of dividends and other distributions to shareholders 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, 2018, these amounts were as follows:

#### ***In millions***

Estimated minimum statutory surplus required by regulators	\$ 5,358
Investments on deposit with regulatory bodies	630
Estimated maximum dividend distributions permitted in 2019 without prior regulatory approval	584

### ***Noncontrolling Interests***

At December 31, 2018, noncontrolling interests were \$318 million primarily related to third party interests in the Company's operating entities. The noncontrolling entities' share is included in total shareholders' equity.

### 13. Other Comprehensive Income (Loss)

Shareholders' equity included the following activity in accumulated other comprehensive income (loss) in 2018, 2017 and 2016:

<i>In millions</i>	At December 31,		
	2018	2017	2016
<b>Net unrealized investment gains (losses):</b>			
Beginning of year balance	\$ —	\$ —	\$ —
Other comprehensive income before reclassifications <i>(\$132 pretax)</i>	97	—	—
Amounts reclassified from accumulated other comprehensive income <i>(\$1 pretax)</i> <sup>(1)</sup>	—	—	—
Other comprehensive income	97	—	—
End of year balance	97	—	—
<b>Foreign currency translation adjustments:</b>			
Beginning of year balance	(129)	(127)	(165)
Other comprehensive income (loss)	(29)	(2)	38
Other comprehensive income (loss)	(29)	(2)	38
End of year balance	(158)	(129)	(127)
<b>Net cash flow hedges:</b>			
Beginning of year balance	(15)	(5)	(7)
Adoption of new accounting standard <sup>(4)</sup>	(3)	—	—
Other comprehensive income (loss) before reclassifications <i>(\$465, \$(18) and \$0 pretax)</i>	344	(11)	—
Amounts reclassified from accumulated other comprehensive loss <i>\$(19), \$2 and \$3 pretax)</i> <sup>(2)</sup>	(14)	1	2
Other comprehensive income (loss)	330	(10)	2
End of year balance	312	(15)	(5)
<b>Pension and OPEB plans:</b>			
Beginning of year balance	(21)	(173)	(186)
Adoption of new accounting standard <sup>(4)</sup>	(4)	—	—
Other comprehensive loss before reclassifications <i>\$(178), \$0 and \$0 pretax)</i>	(132)	—	—
Amounts reclassified from accumulated other comprehensive loss <i>(\$11, \$249 and \$21 pretax)</i> <sup>(3)</sup>	8	152	13
Other comprehensive income (loss)	(124)	152	13
End of year balance	(149)	(21)	(173)
Total beginning of year accumulated other comprehensive loss	(165)	(305)	(358)
Adoption of new accounting standard <sup>(4)</sup>	(7)	—	—
Total other comprehensive income	274	140	53
Total end of year accumulated other comprehensive income (loss)	\$ 102	\$ (165)	\$ (305)

- (1) Amounts reclassified from accumulated other comprehensive income for debt securities are included in net investment income within the consolidated statements of operations.
- (2) Amounts reclassified from accumulated other comprehensive loss for specifically identified cash flow hedges are included within interest expense in the consolidated statements of operations.
- (3) Amounts reclassified from accumulated other comprehensive loss for specifically identified pension and other postretirement benefits are included in other (income) expense in the consolidated statements of operations.
- (4) See Note 1 "Significant Accounting Policies" for additional information on the adoption of ASU 2018-02 during the first quarter of 2018.

### 14. Earnings 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. 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. In addition, options to purchase 13.2 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 because the exercise prices of the options were greater than the average market price of the common shares and, therefore, the effect would be antidilutive. For the same reason, options to purchase 10.4 million and 6.7 million shares of common stock were outstanding, but were excluded from the calculation of diluted earnings per share, for the years ended December 31, 2017 and 2016, respectively.

The following is a reconciliation of basic and diluted earnings (loss) per share from continuing operations for the years ended December 31:

<i><u>In millions, except per share amounts</u></i>	<b>2018</b>	<b>2017</b>	<b>2016</b>
<b>Numerator for earnings per share calculation:</b>			
Income (loss) from continuing operations	\$ (596)	\$ 6,631	\$ 5,320
Income allocated to participating securities	(3)	(24)	(27)
Net (income) loss attributable to noncontrolling interests	2	(1)	(2)
Income (loss) from continuing operations attributable to CVS Health	<u>\$ (597)</u>	<u>\$ 6,606</u>	<u>\$ 5,291</u>
<b>Denominator for earnings per share calculation:</b>			
Weighted average shares, basic	1,044	1,020	1,073
Effect of dilutive securities	—	4	6
Weighted average shares, diluted	<u>1,044</u>	<u>1,024</u>	<u>1,079</u>
<b>Earnings (loss) per share from continuing operations:</b>			
Basic	\$ (0.57)	\$ 6.48	\$ 4.93
Diluted	\$ (0.57)	\$ 6.45	\$ 4.91

## 15. Reinsurance

The Company utilizes reinsurance agreements primarily to reduce required capital and to 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, Aetna completed the sale of its standalone Medicare Part D prescription drug plans to a subsidiary of WellCare, effective December 31, 2018. In connection with that sale, subsidiaries of WellCare and Aetna entered into reinsurance agreements under which WellCare has 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 2019, the Company entered into two four-year reinsurance agreements with an unrelated reinsurer that allowed it to reduce required capital and provided 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, 2018 were as follows:

### *In millions*

#### **Reinsurer**

Hartford Life and Accident Insurance Company	\$ 3,470
Lincoln Life & Annuity Company of New York	424
Constitution Life	320
VOYA Retirement Insurance and Annuity Company	186
All Other	141
Total	<u>\$ 4,541</u>

Direct, assumed and ceded premiums earned for the year ended December 31, 2018 were as follows:

***In millions***

Direct	\$ 8,365
Assumed	38
Ceded	(219)
Net premiums	<u>\$ 8,184</u>

The impact of reinsurance on benefit costs for the year ended December 31, 2018 was as follows:

***In millions***

Direct	\$ 6,773
Assumed	32
Ceded	(211)
Net benefit costs	<u>\$ 6,594</u>

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. These contracts were entered into to reduce the risk of catastrophic loss which in turn reduces the Company's capital and surplus requirements for certain portions of its group term life insurance and group accidental death and dismemberment insurance businesses and certain portions of the Health Care Benefits segment's Medicare Advantage and group Commercial Insured businesses. 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, 2018.

## **16. Commitments and Contingencies**

### ***Guarantees***

The Company has the following significant guarantee arrangements at December 31, 2018:

- **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 December 31, 2018. See Note 1 "Significant Accounting Policies" for additional information on Separate Accounts. Contract holders assume all investment and mortality risk and are required to maintain Separate Accounts balances at or above a specified level. The level of required funds is a function of the risk underlying the Separate Account's investment strategy. If contract holders do not maintain the required level of Separate Accounts assets to meet the annuity guarantees, the Company would establish an additional liability. Contract holders' balances in the Separate Accounts at December 31, 2018 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, 2018.

### ***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. When the subsidiaries were disposed of and accounted for as discontinued operations, the Company's guarantees remained in place, although each initial purchaser agreed

to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries fail to make the required payments under a store lease, the Company could be required to satisfy those obligations. As of December 31, 2018, the Company guaranteed approximately 85 such store leases (excluding the lease guarantees related to Linens 'n Things, which have been recorded as a liability on the consolidated balance sheet), with the maximum remaining lease term extending through 2029.

### ***Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools***

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. During the first quarter of 2017, Aetna recorded a discounted estimated liability and expense of \$231 million pretax for its estimated share of future assessments by applicable life and health guaranty associations which reflects a 3.5% discount rate. The Company did not record an asset for expected premium tax offsets for its in force business at December 31, 2018, as the amount was not material. 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 results of operations, financial condition and cash flows. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may 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 total guaranty fund assessments liability as of December 31, 2018 was \$90 million and was recorded in accrued expenses on the consolidated balance sheet.

### ***Litigation and Regulatory Proceedings***

The Company is a party to numerous legal proceedings, investigations, audits and claims arising, for the most part, in the ordinary course of its businesses, including the matters described below. The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial condition.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. It is reasonably possible that the outcome of such legal matters could be material to the Company.

#### **Usual and Customary Litigation**

The Company is named as a defendant in a number of litigations that allege that the Company's retail stores overcharged for prescription drugs by not providing the correct usual and customary charge.

*State of Texas ex rel. Myron Winkelman and Stephani Martinson, et al. v. CVS Health Corporation* (Travis County Texas District Court). In February 2012, the Attorney General of the State of Texas issued Civil Investigative Demands (“CIDs”) to the Company and subsequently has issued a series of requests for documents and information in connection with its investigation concerning the CVS Health Savings Pass program and other pricing practices with respect to claims for reimbursement from the Texas Medicaid program. In January 2017, the Travis County Court unsealed a first amended *qui tam* petition filed in April 2014. The government has intervened in this case. The amended petition alleges the Company violated the Texas Medicaid Fraud Prevention Act by submitting false claims for reimbursement to the Texas Medicaid program by, among other things, failing to use the price available to members of the CVS Health Savings Pass program as the pharmacies’ usual and customary price. The amended petition was unsealed following the Company’s December 2016 filing of *CVS Pharmacy, Inc. v. Charles Smith, et al.* (Travis County Texas District Court), a declaratory judgment action against the State of Texas seeking a declaration that the prices charged to members of the CVS Health Savings Pass program do not constitute usual and customary prices under the applicable Medicaid regulation. In March 2018, the Travis County Court denied the State of Texas’s request for temporary injunctive relief. The Company is defending itself against these claims.

*Corcoran et al. v. CVS Health Corporation* (U.S. District Court for the Northern District of California) and *Podgorny et al. v. CVS Health Corporation* (U.S. District Court for the Northern District of Illinois). These putative class actions were filed against the Company in July and September 2015. The cases were consolidated in the U.S. District Court for the Northern District of California. Plaintiffs seek damages and injunctive relief under the consumer protection statutes and common laws of certain states on behalf of a class of consumers who purchased certain prescription drugs. Several third-party payors filed similar putative class actions on behalf of payors captioned *Sheet Metal Workers Local No. 20 Welfare and Benefit Fund v. CVS Health Corp.* and *Plumbers Welfare Fund, Local 130 v. CVS Health Corporation* (both pending in the U.S. District Court for the District of Rhode Island) in February and August 2016. In all of these cases the plaintiffs allege the Company overcharged for certain prescription drugs by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy’s usual and customary price. In the *Corcoran* case, the U.S. District Court granted summary judgment to CVS on plaintiffs’ claims in their entirety and certified certain subclasses in September 2017. The *Corcoran* plaintiffs have appealed the District Court’s decision to the Ninth Circuit. The *Sheet Metal Workers* plaintiffs have amended their complaint to assert a claim under the federal Racketeer Influenced and Corrupt Organizations Act (“RICO”) premised on an alleged conspiracy between the Company and other PBMs. The Company is defending itself against these claims.

*State of California ex rel. Matthew Omlansky v. CVS Caremark Corporation* (Superior Court of the State of California, County of Sacramento). In April 2016, the California Superior Court unsealed a first amended *qui tam* complaint filed in July 2013. The government has declined to intervene in this case. The relator alleges that the Company submitted false claims for payment to the California Medicaid program in connection with reimbursement for drugs available through the CVS Health Savings Pass program as well as certain other generic drugs. The case has been stayed pending the relator’s appeal of the judgment against him in a similar case against another retailer. The Company is defending itself against these claims.

*State of Mississippi v. CVS Health Corporation, et al.* (Chancery Court of DeSoto County, Mississippi, Third Judicial District). In July 2016, the Company was served with a complaint filed on behalf of the State of Mississippi alleging that CVS retail pharmacies in Mississippi submitted false claims for reimbursement to the Mississippi Medicaid program by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy’s usual and customary price. The Company has responded to the complaint, moved for judgment on the pleadings, filed a counterclaim and moved the case to Mississippi Circuit Court. The Company’s motion for judgment on the pleadings remains pending. The Company is defending itself against these claims.

#### Manufacturer’s Rebate Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning manufacturer’s rebates that the Company has negotiated.

*Bewley, et al. v. CVS Health Corporation, et al.* and *Prescott, et al. v. CVS Health Corporation, et al.* (both pending in the U.S. District Court for the Western District of Washington). These putative class actions were filed against the Company and other PBMs and manufacturers of glucagon kits (*Bewley*) and diabetes test strips (*Prescott*) in May 2017. Both cases allege that, by contracting for rebates with the manufacturers of these diabetes products, the Company and other PBMs caused list prices for these products to increase, thereby harming certain consumers. The plaintiffs’ primary claims are made under federal antitrust laws, RICO, state unfair competition and consumer protection laws and the federal Employee Retirement Income Security Act of 1974 (“ERISA”). Both of these cases have been transferred to the U.S. District Court for the District of New Jersey on defendants’ motions. The Company is defending itself against these claims.

*Klein, et al. v. Prime Therapeutics, et al.* (U.S. District Court for the District of Minnesota). This putative class action was filed against the Company and other PBMs in June 2017 on behalf of ERISA plan members who purchased and paid for EpiPen or EpiPen Jr. Plaintiffs allege that the PBMs are ERISA fiduciaries to plan members and have violated ERISA by allegedly causing higher inflated prices for EpiPens through the process of negotiating increased rebates from EpiPen manufacturer Mylan. This case has been consolidated with a similar matter and is now proceeding as *In re EpiPen ERISA Litigation*. The Company is defending itself against these claims.

In April 2017, the Company received a CID from the Attorney General of Washington requesting documents and information regarding pricing and rebates for insulin products in connection with a pending investigation into unfair and deceptive acts or practices regarding insulin pricing. The Office of the Attorney General of Washington has notified the Company that information provided in response to the Washington Attorney General's CID will be shared with the Attorneys General of California, Florida, Minnesota, New Mexico, the District of Columbia and Mississippi. In July 2017, the Company received a CID from the Attorney General of Minnesota requesting documents and information regarding pricing and rebates for insulin and epinephrine products in connection with a pending investigation into unfair and deceptive acts or practices regarding insulin and epinephrine pricing. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

#### Controlled Substances Litigation, Audits and Subpoenas

In December 2017, the U.S. Judicial Panel on Multidistrict Litigation consolidated numerous cases filed against various defendants by plaintiffs such as counties, cities, hospitals, Indian tribes and third-party payors, alleging claims generally concerning the impacts of widespread opioid abuse. The consolidated multidistrict litigation captioned *In re National Prescription Opiate Litigation* (MDL No. 2804) is pending in the U.S. District Court for the Northern District of Ohio. This multidistrict litigation presumptively includes hundreds of relevant federal court cases that name the Company as a defendant. Fewer than 100 similar cases that name the Company as a defendant in some capacity are pending in state courts. 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 the Attorneys General of several states. The Company has been cooperating with the government with respect to these subpoenas, CIDs and other requests for information.

The Company routinely is audited by the United States Drug Enforcement Administration ("DEA"). For several of these audits, the Company is in discussions with the DEA and U.S. Attorney's Offices concerning allegations that the Company violated certain requirements of the Controlled Substance Act.

In September 2015, the DEA served Omnicare with an administrative subpoena. The subpoena seeks documents related to controlled substance policies, procedures and practices at eight Company pharmacy locations from May 2012 to the present. In September 2017, the DEA expanded the investigation to include an additional Company pharmacy location. The Company has been cooperating with the government and providing documents and witnesses in response to this subpoena.

#### Prescription Processing Investigations

In October 2015, Omnicare received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning Omnicare's cycle fill process for assisted living facilities. The Company has been cooperating with the government and providing documents and information in response to this CID. In July 2017, Omnicare also received a subpoena from the California Department of Insurance requesting documents concerning similar subject matter. The Company has been cooperating with the California Department of Insurance and providing documents and information in response to this subpoena.

In December 2016, the Company received a CID from the U.S. Attorney's Office for the Northern District of New York requesting documents and information in connection with a federal False Claims Act investigation concerning whether the Company's retail pharmacies improperly submitted certain insulin claims to Part D of the Medicare program rather than Part B of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to this CID.

In May 2017, the Company received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning possible false claims submitted to Medicare in connection with reimbursements for prescription drugs under the Medicare Part D program. The Company has been cooperating with the government and providing documents and information in response to this CID.

## Provider Proceedings

The Company is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by health care providers with whom the Company has a contract and with whom the Company does not have a contract (“out-of-network providers”). Among other things, these lawsuits allege that the Company paid too little to its health plan members and/or providers for these services and/or otherwise allege that the Company failed to timely or appropriately pay or administer claims and benefits (including the Company’s post payment audit and collection practices and reductions in payments to providers due to sequestration). Other major health insurers are the subject of similar litigation or have settled similar litigation.

On October 28, 2016, Aetna was named as a respondent in an arbitration proceeding that had commenced as a lawsuit in Florida state court on August 25, 2015. The arbitration proceeding was brought by hospitals owned by HCA Holdings, Inc. with respect to Aetna’s out-of-network benefit payment and administration practices in Florida relating to services and care rendered to members in Aetna’s individual Public Exchange products from 2014 through 2016. Coverage under Aetna’s individual Public Exchange products in Florida was not available after December 31, 2016. On October 15, 2018, the arbitrator awarded the claimant hospitals approximately \$150 million. The Company is defending itself against the claimant hospitals’ claims and has appealed the arbitrator’s decision.

The Company also has received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to, and the Company is involved in other litigation regarding, its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against the Company with respect to its out-of-network benefit payment and/or administration practices.

## CMS Actions

CMS regularly audits the Company’s performance to determine its compliance with CMS’s regulations and its contracts with CMS and to assess the quality of services it provides to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to the Company’s and other companies’ Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. The Company collects claim and encounter data from providers and generally relies on providers to appropriately code their submissions to the Company and document their medical records, including the diagnosis data submitted to the Company with claims. CMS pays increased premiums to Medicare Advantage plans and Medicare PDP plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers’ medical records to determine whether those records support the related diagnosis codes that determine the members’ health status and the resulting risk-adjusted premium payments to the Company. In that regard, CMS has instituted risk adjustment data validation (“RADV”) audits of various Medicare Advantage plans, including certain of the Company’s plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require the Company to refund premium payments if the Company’s risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (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 project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. For contract years prior to 2011, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase 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. 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, HHS or otherwise, including audits of the Company’s minimum MLR rebates, methodology and/or reports, could be material and could adversely affect the Company’s results of operations, financial condition and/or cash flows.

## Medicare CIDs

The Company has received CIDs from the Civil Division of the DOJ in connection with a current investigation of the Company's patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

## Tunney Act Proceeding

On October 10, 2018, the Company and Aetna entered into a consent decree with the DOJ that allowed CVS Health's proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone Medicare Part D prescription drug plans. As permitted by the asset preservation stipulation and order dated October 25, 2018, CVS Health completed its acquisition of Aetna on November 28, 2018, and Aetna completed the sale of such plans on November 30, 2018. The consent decree remains subject to the court approval process under the Antitrust Procedures and Penalties Act, which could result in a revision in or delay in receiving approval of the consent decree. The approval process is for the limited purpose of determining whether the consent decree is in the public interest. The Company believes that the consent decree will not have a material impact on the Company's results of operations, cash flows or financial condition.

## 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, all arising in the ordinary course of its businesses. These other legal proceedings include claims of or relating to bad faith, medical malpractice, 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 contracts with government customers in the Company's Commercial Health Care Benefits segment, are subject to increasingly frequent 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 results of operations. 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 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 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, however, that its businesses, financial condition, results of operations 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 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.

## **17. Segment Reporting**

The Company currently 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 for which results of operations are evaluated on a regular basis by the Company's chief operating decision maker in deciding how to allocate resources and in assessing performance.

The Company evaluates its Pharmacy Services, Retail/LTC and Health Care Benefits segments' performance based on operating income (loss) and operating income (loss) before the effect of (i) nonrecurring charges or gains and (ii) certain intersegment activities. The chief operating decision maker does not use total assets by segment to make decisions regarding resources. Therefore the total asset disclosure by segment has not been included. See Note 1 "Significant Accounting Policies" for a description of the Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other segments and related significant accounting policies.

In 2018, 2017 and 2016, approximately 9.8%, 12.3% and 11.7%, respectively, of the Company's consolidated revenues were from Aetna, a Pharmacy Services segment client. On November 28, 2018, the Company completed the Aetna Acquisition. Subsequent to the Aetna Acquisition, transactions with Aetna will continue to be reported within the Pharmacy Services segment, but are eliminated in the Company's consolidated financial statements.

Effective for the first quarter of 2019, the Company will realign the composition of its segments to correspond with changes to its operating model. As a result of this realignment, the Company's Silverscript PDP will move from the Pharmacy Services segment to the Health Care Benefits segment. In addition, the Company will move Aetna's mail order and specialty pharmacy operations from the Health Care Benefits segment to the Pharmacy Services segment.

<i><u>In millions</u></i>	<b>Pharmacy Services <sup>(1)(2)</sup></b>	<b>Retail/ LTC <sup>(2)</sup></b>	<b>Health Care Benefits <sup>(2)</sup></b>	<b>Corporate/ Other</b>	<b>Intersegment Eliminations <sup>(2)</sup></b>	<b>Consolidated Totals</b>
<b>2018:</b>						
Revenues from customers	\$ 134,115	\$ 83,989	\$ 5,504	\$ 4	\$ (29,693)	\$ 193,919
Net investment income <sup>(3)</sup>	13	—	45	602	—	660
Total revenues	134,128	83,989	5,549	606	(29,693)	194,579
Operating income (loss) <sup>(4)(5)</sup>	4,699	620	276	(805)	(769)	4,021
Depreciation and amortization	712	1,698	170	138	—	2,718
Additions to property and equipment	326	1,350	46	401	—	2,123
<b>2017:</b>						
Revenues from customers	130,596	79,398	—	—	(25,229)	184,765
Net investment income	5	—	—	16	—	21
Total revenues <sup>(7)</sup>	130,601	79,398	—	16	(25,229)	184,786
Operating income (loss) <sup>(4)(5)(7)</sup>	4,657	6,558	—	(936)	(741)	9,538
Depreciation and amortization	712	1,651	—	116	—	2,479
Additions to property and equipment	311	1,398	—	340	—	2,049
<b>2016:</b>						
Revenues from customers	119,963	81,100	—	—	(23,537)	177,526
Net investment income	2	—	—	18	—	20
Total revenues <sup>(7)</sup>	119,965	81,100	—	18	(23,537)	177,546
Operating income (loss) <sup>(4)(5)(6)(7)</sup>	4,570	7,437	—	(900)	(721)	10,386
Depreciation and amortization	714	1,642	—	119	—	2,475
Additions to property and equipment	295	1,732	—	252	—	2,279

- (1) Total revenues of PSS include approximately \$11.4 billion, \$10.8 billion and \$10.5 billion of Retail Co-Payments for 2018, 2017 and 2016, respectively. See Note 1 “Significant Accounting Policies” for additional information about Retail Co-Payments.
- (2) Intersegment eliminations relate to intersegment revenue generating activities that occur between PSS and RLS for 2018, 2017 and 2016. Effective November 28, 2018, intersegment eliminations also relate to intersegment revenue generating activities that occur between HCBS, PSS and/or RLS.
- (3) Corporate/Other segment net investment income for 2018 includes interest income of \$536 million related to the proceeds of the \$40 billion 2018 Notes. This amount is for the period prior to the close of the Aetna Acquisition, which occurred on November 28, 2018.
- (4) RLS operating income for 2018, 2017 and 2016 includes \$7 million, \$34 million and \$281 million, respectively, of acquisition-related integration costs. The integration costs in 2018 and 2017 are related to the acquisition of Omnicare. The integration costs in 2016 are related to the acquisitions of Omnicare and the pharmacy and clinic businesses of Target. RLS operating income for 2018 and 2017 also includes goodwill impairment charges of \$6.1 billion related to the LTC reporting unit and \$181 million related to the RxCrossroads reporting unit, respectively. In addition, RLS operating income for 2017 and 2016 includes \$215 million and \$34 million, respectively, of charges associated with store rationalization and asset impairment charges in connection with planned store closures related to the Company’s enterprise streamlining initiative. RLS operating income for 2018 also includes a \$43 million loss on impairment of long-lived assets primarily related to the impairment of property and equipment and an \$86 million loss on the divestiture of the Company’s RxCrossroads subsidiary.
- (5) Corporate/Other segment operating loss for 2018, 2017 and 2016 includes \$485 million, \$40 million and \$10 million, respectively, of divestiture and acquisition-related transaction and integration costs included in operating expenses in the consolidated statements of operations. The transaction and integration costs in 2018 are related to the acquisitions of Aetna and Omnicare. The transaction and integration costs in 2017 are related to the acquisitions of Aetna and Omnicare and the divestiture of RxCrossroads. The integration costs in 2016 are related to the acquisitions of Omnicare and the pharmacy and clinic businesses of Target.
- (6) PSS operating income for 2016 includes the reversal of an accrual of \$88 million in connection with a legal settlement.
- (7) Amounts revised to reflect the reclassification of interest income from interest expense, net to net investment income within total revenues to conform with insurance company presentation which increased total revenues and operating income by \$21 million and \$20 million in 2017 and 2016, respectively.

In conjunction with the Company's implementation of a new enterprise resource planning system in the first quarter of 2018, the Company changed the manner in which certain shared functional costs are allocated to its reportable segments.

Additionally, in connection with the Aetna Acquisition on November 28, 2018, the Company reclassified interest income from interest expense, net to net investment income within revenues to conform with insurance company presentation. Segment financial information for the years ended December 31, 2017 and 2016, have been retrospectively adjusted to reflect this change to the Company's cost allocation methodology and net investment income presentation as shown below:

<i>In millions</i>	Year Ended December 31, 2017				
	Pharmacy Services	Retail/ LTC	Corporate/ Other	Intersegment Eliminations	Consolidated Totals
Revenues, as previously reported	\$ 130,596	\$ 79,398	\$ —	\$ (25,229)	\$ 184,765
Adjustments	5	—	16	—	21
Revenues, as adjusted	\$ 130,601	\$ 79,398	\$ 16	\$ (25,229)	\$ 184,786
Cost of products sold <sup>(1)</sup>	\$ 121,746	\$ 56,081	\$ —	\$ (24,417)	\$ 153,410
Adjustments	53	(15)	—	—	38
Cost of products sold	\$ 121,799	\$ 56,066	\$ —	\$ (24,417)	\$ 153,448
Benefit costs <sup>(1)</sup>	\$ 2,810	\$ —	\$ —	\$ —	\$ 2,810
Adjustments	—	—	—	—	—
Benefit costs	\$ 2,810	\$ —	\$ —	\$ —	\$ 2,810
Operating expenses, as previously reported	\$ 1,285	\$ 16,848	\$ 966	\$ (71)	\$ 19,028
Adjustments	50	(74)	(14)	—	(38)
Operating expenses, as adjusted	\$ 1,335	\$ 16,774	\$ 952	\$ (71)	\$ 18,990
Operating income (loss), as previously reported	\$ 4,755	\$ 6,469	\$ (966)	\$ (741)	\$ 9,517
Adjustments	(98)	89	30	—	21
Operating income (loss), as adjusted	\$ 4,657	\$ 6,558	\$ (936)	\$ (741)	\$ 9,538

(1) The total of cost of products sold and benefit costs previously was reported as cost of revenues.

**Year Ended December 31, 2016**

<i>In millions</i>	Pharmacy Services	Retail/ LTC	Corporate/ Other	Intersegment Eliminations	Consolidated Totals
Revenues, as previously reported	\$ 119,963	\$ 81,100	\$ —	\$ (23,537)	\$ 177,526
Adjustments	2	—	18	—	20
Revenues, as adjusted	<u>\$ 119,965</u>	<u>\$ 81,100</u>	<u>\$ 18</u>	<u>\$ (23,537)</u>	<u>\$ 177,546</u>
Cost of products sold <sup>(1)</sup>	\$ 111,883	\$ 57,362	\$ —	\$ (22,755)	\$ 146,490
Adjustments	66	(23)	—	—	43
Cost of products sold	<u>\$ 111,949</u>	<u>\$ 57,339</u>	<u>\$ —</u>	<u>\$ (22,755)</u>	<u>\$ 146,533</u>
Benefit costs <sup>(1)</sup>	\$ 2,179	\$ —	\$ —	\$ —	\$ 2,179
Adjustments	—	—	—	—	—
Benefit costs	<u>\$ 2,179</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ 2,179</u>
Operating expenses, as previously reported	\$ 1,225	\$ 16,436	\$ 891	\$ (61)	\$ 18,491
Adjustments	42	(112)	27	—	(43)
Operating expenses, as adjusted	<u>\$ 1,267</u>	<u>\$ 16,324</u>	<u>\$ 918</u>	<u>\$ (61)</u>	<u>\$ 18,448</u>
Operating income (loss), as previously reported	\$ 4,676	\$ 7,302	\$ (891)	\$ (721)	\$ 10,366
Adjustments	(106)	135	(9)	—	20
Operating income (loss), as adjusted	<u>\$ 4,570</u>	<u>\$ 7,437</u>	<u>\$ (900)</u>	<u>\$ (721)</u>	<u>\$ 10,386</u>

(1) The total of cost of products sold and benefit costs previously was reported as cost of revenues.

## 18. Quarterly Financial Information (Unaudited)

<i><u>In millions, except per share amounts</u></i>	<b>First Quarter</b>	<b>Second Quarter</b>	<b>Third Quarter</b>	<b>Fourth Quarter</b>	<b>Year</b>
<b>2018:</b>					
Total revenues <sup>(1)</sup>	\$ 45,743	\$ 46,922	\$ 47,490	\$ 54,424	\$ 194,579
Operating income (loss) <sup>(1)</sup>	1,996	(1,373)	2,574	824	4,021
Income (loss) from continuing operations	998	(2,562)	1,390	(422)	(596)
Net income (loss) attributable to CVS Health	998	(2,563)	1,390	(419)	(594)
<b>Per common share data:</b>					
<b>Basic earnings (loss) per common share:</b>					
Income (loss) from continuing operations attributable to CVS Health	\$ 0.98	\$ (2.52)	\$ 1.36	\$ (0.37)	\$ (0.57)
Income (loss) from discontinued operations attributable to CVS Health	\$ —	\$ —	\$ —	\$ —	\$ —
Net income (loss) attributable to CVS Health	\$ 0.98	\$ (2.52)	\$ 1.36	\$ (0.37)	\$ (0.57)
<b>Diluted earnings (loss) per common share:</b>					
Income (loss) from continuing operations attributable to CVS Health	\$ 0.98	\$ (2.52)	\$ 1.36	\$ (0.37)	\$ (0.57)
Income (loss) from discontinued operations attributable to CVS Health	\$ —	\$ —	\$ —	\$ —	\$ —
Net income (loss) attributable to CVS Health	\$ 0.98	\$ (2.52)	\$ 1.36	\$ (0.37)	\$ (0.57)
Dividends per common share	\$ 0.50	\$ 0.50	\$ 0.50	\$ 0.50	\$ 2.00

(1) Effective for the fourth quarter of 2018, interest income was reclassified from interest expense, net to net investment income within revenues to conform with insurance company presentation. Accordingly, a retrospective reclassification of \$50 million, \$214 million and \$221 million was made for the first, second and third quarters of 2018, respectively, to increase revenues and increase interest expense.

<i><b>In millions, except per share amounts</b></i>	<b>First Quarter</b>	<b>Second Quarter</b>	<b>Third Quarter</b>	<b>Fourth Quarter</b>	<b>Year</b>
<b>2017:</b>					
Total revenues <sup>(1)</sup>	\$ 44,520	\$ 45,689	\$ 46,186	\$ 48,391	\$ 184,786
Operating income <sup>(1)</sup>	1,799	2,121	2,504	3,114	9,538
Income from continuing operations	962	1,097	1,285	3,287	6,631
Net income attributable to CVS Health	952	1,098	1,285	3,287	6,622
<b>Per common share data:</b>					
<b>Basic earnings per common share:</b>					
Income from continuing operations attributable to CVS Health	\$ 0.93	\$ 1.07	\$ 1.26	\$ 3.23	\$ 6.48
Income (loss) from discontinued operations attributable to CVS Health	\$ (0.01)	\$ —	\$ —	\$ —	\$ (0.01)
Net income attributable to CVS Health	\$ 0.92	\$ 1.07	\$ 1.26	\$ 3.23	\$ 6.47
<b>Diluted earnings per common share:</b>					
Income from continuing operations attributable to CVS Health	\$ 0.92	\$ 1.07	\$ 1.26	\$ 3.22	\$ 6.45
Income (loss) from discontinued operations attributable to CVS Health	\$ (0.01)	\$ —	\$ —	\$ —	\$ (0.01)
Net income attributable to CVS Health	\$ 0.92	\$ 1.07	\$ 1.26	\$ 3.22	\$ 6.44
Dividends per common share	\$ 0.50	\$ 0.50	\$ 0.50	\$ 0.50	\$ 2.00

(1) Effective for the fourth quarter of 2018, interest income was reclassified from interest expense, net to net investment income within revenues to conform with insurance company presentation. Accordingly, a retrospective reclassification of \$6 million, \$4 million, \$5 million and \$6 million was made for the first, second, third and fourth quarters of 2017, respectively, to increase revenues and increase interest expense.

### Five-Year Financial Summary

<i><u>In millions, except per share amounts</u></i>	<u>2018</u> <sup>(2)</sup>	<u>2017</u>	<u>2016</u>	<u>2015</u>	<u>2014</u>
<b>Statement of operations data:</b>					
Total revenues <sup>(1)</sup>	\$ 194,579	\$ 184,786	\$ 177,546	\$ 153,311	\$ 139,382
Operating income <sup>(1)</sup>	4,021	9,538	10,386	9,496	8,837
Income (loss) from continuing operations	(596)	6,631	5,320	5,230	4,645
Net income (loss) attributable to CVS Health	(594)	6,622	5,317	5,237	4,644
<b>Per common share data:</b>					
<b>Basic earnings (loss) per common share:</b>					
Income (loss) from continuing operations attributable to CVS Health	\$ (0.57)	\$ 6.48	\$ 4.93	\$ 4.65	\$ 3.98
Income (loss) from discontinued operations attributable to CVS Health	\$ —	\$ (0.01)	\$ —	\$ 0.01	\$ —
Net income (loss) attributable to CVS Health	\$ (0.57)	\$ 6.47	\$ 4.93	\$ 4.66	\$ 3.98
<b>Diluted earnings (loss) per common share:</b>					
Income (loss) from continuing operations attributable to CVS Health	\$ (0.57)	\$ 6.45	\$ 4.91	\$ 4.62	\$ 3.96
Income (loss) from discontinued operations attributable to CVS Health	\$ —	\$ (0.01)	\$ —	\$ 0.01	\$ —
Net income (loss) attributable to CVS Health	\$ (0.57)	\$ 6.44	\$ 4.90	\$ 4.63	\$ 3.96
Dividends per common share	\$ 2.00	\$ 2.00	\$ 1.70	\$ 1.40	\$ 1.10
<b>Balance sheet and other data:</b>					
Total assets	\$ 196,456	\$ 95,131	\$ 94,462	\$ 92,437	\$ 73,202
Long-term debt	\$ 71,444	\$ 22,181	\$ 25,615	\$ 26,267	\$ 11,630
Total shareholders' equity	\$ 58,543	\$ 37,695	\$ 36,834	\$ 37,203	\$ 37,963
Number of stores (at end of year)	9,967	9,846	9,750	9,681	7,866

(1) Effective for the fourth quarter of 2018, interest income was reclassified from interest expense, net to net investment income within revenues to conform with insurance company presentation. Accordingly, a retrospective reclassification of \$21 million, \$20 million, \$21 million and \$15 million was made for years ended December 31, 2017, 2016, 2015 and 2014, respectively, to increase revenues and increase interest expense.

(2) On November 28, 2018, the Company acquired Aetna. Aetna's operations are included in the Company's consolidated financial statements for the period from November 28, 2018 to December 31, 2018 and the period then ended. See Note 2 "Acquisition of Aetna" of Notes to Consolidated Financial Statements for additional information.

## 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, 2018 and 2017, 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, 2018, 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, 2018 and 2017, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018, 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, 2018, 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 28, 2019 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.

/s/ Ernst & Young LLP

We have served as the Company's auditor since 2007.

Boston, Massachusetts  
February 28, 2019