The secret object #5 is a "comb".

Building a world of health around every consumer.

CVS Health®

2023 Annual Report

Dear Fellow Stockholders:

Karen S. Lynch
President and Chief Executive Officer

Our more than 300,000 purpose-driven colleagues work every day to build a world of health around every consumer, improving outcomes, lowering costs and broadening access to quality care. We are bringing our heart to every moment of health for the people and communities we serve.

In 2023, we made tangible progress to transform how care is delivered in this country, bringing together integrated health solutions that meet the needs of consumers. We advanced our strategy and strengthened our position for continued success in 2024.

Delivering strong performance through a diversified portfolio

Last year we successfully navigated a challenging environment while delivering on our financial commitments. We grew total revenues to approximately $358 billion, an 11 percent increase over 2022, and delivered adjusted operating income of $17.5 billion* and adjusted earnings per share of $8.74*. During the year, we generated $13.4 billion in cash flow from operations, demonstrating the power of our business model. This performance enabled us to return more than $5 billion to stockholders through dividend payments and common stock repurchases.

In the Health Care Benefits segment, we ended the year with nearly 26 million members, an increase of 1.3 million members versus the prior year, reflecting increases in the Commercial and Medicare product lines, including Individual Exchange business within the Commercial product line. We offered our Individual Exchange products in 12 states in 2023, and in 2024 we will expand to a total of 17 states. Our success was driven by compelling offerings that were strengthened by CVS Health® assets, allowing us to create differentiated value for members.

In the Health Services segment, we launched a new brand, CVS Healthspire™, that brings together our health care delivery, pharmacy benefit management and health services solutions. These businesses will accelerate our ability to transform health care and to drive superior health outcomes at lower costs while offering a seamless consumer experience.

Our ability to consistently deliver exceptional customer and member experiences, while making medicine more affordable, makes CVS Caremark® a leader in the marketplace. In 2023, CVS Caremark served approximately 108 million members and processed 2.3 billion pharmacy claims on a 30-day equivalent basis. Our deep understanding of the practice of pharmacy allows us to deliver lower costs in the pharmaceutical marketplace, leading to better health outcomes.

In the Pharmacy & Consumer Wellness (PCW) segment, we filled more than 1.6 billion prescriptions and administered nearly 30 million vaccines. We invested in digital capabilities to help drive productivity in our business. More than 40 percent of our CVS Pharmacy® customers are engaging with us digitally for their pharmacy and well-being needs. Our local community presence allows us to connect millions of people across different sites of care to improve health in ways others can.

The secret animal #3 is a "dolphin".

By bringing together the powerful capabilities of our brands, we can unlock up to three to four times more enterprise value when we engage members in more than one CVS Health business. Our capabilities allow us to connect with consumers in more places—in the community, in the home and virtually.

Advancing the future of care delivery

We have both the scale to transform how health care is delivered, and the ability to personalize care and coverage for each individual we serve.

In 2023, we made significant progress on our value-based care delivery strategy. We broadened our value-based care capabilities into the home with the acquisitions of Signify Health®, which expanded our reach into consumers' homes with Signify Health conducting 2.6 million in-home evaluations over the course of 2023. Over time, we expect to utilize the strong capabilities of Signify Health in other businesses, including Individual Exchange and Medicaid.

Our acquisition of Oak Street Health® extends our ability to provide primary care services and gives us momentum in engaging multi-payor Medicare Advantage members with Oak Street Health clinics. In 2023, there were more than 6 million visits to MinuteClinic® locations, our retail health clinics. We also grew our physician enablement business, CVS Accountable Care™, which had approximately $10 billion of managed spend in 2023 and is expected to grow to more than 1 million patients in 2024. elerate value of CVS Health. Together, MinuteClinic and Oak Street Health makes CVS Health one of the largest providers of primary and episodic care in the United States. Collectively, we are effectively combining a unique and integrated platform of capabilities that lead to high quality of care, lower costs and better health outcomes.

Beyond engaging consumers, we believe emerging technologies will accelerate the transformation in

The secret object #1 is a "book".

health care. We are embedding technology, data and analytics in every aspect of our business. The effects will be positive and profound, and we're already seeing significant value, while preserving the importance of the human connection in health care.

Driving pharmacy innovation for greater access and affordability

We are committed to continuously innovating to improve the choices we offer our customers, health plan clients and consumers. In 2023, we further expanded our role in ensuring access to high quality, reliable and cost-effective prescription therapies.

We launched Cordavis,™ a wholly-owned subsidiary that works directly with pharmaceutical manufacturers to commercialize and/or co-produce biosimilar products. It builds on our history of finding ways to lower drug costs and ensure people have access to the medications they need to stay healthy, especially for high-priced specialty drugs. We expect that Cordavis will support a viable and durable biosimilar market at scale in the United States, a market which is projected to grow to more than $100 billion by 2029.

We also announced two exciting new models, CVS CostVantage™ in CVS Pharmacy® and TrueCost™ in CVS Caremark®. CVS CostVantage offers a new approach to the pharmacy reimbursement model that delivers great transparency and simplicity to the system. The new model can create a more sustainable pharmacy market and will ensure that CVS Pharmacy locations continue to be a critical touchpoint for consumers to access affordable health care in their communities. Cash paying patients are expected to begin benefitting from CVS CostVantage in 2024, and it will become available to pharmacy benefit managers (PBMs) in 2025.

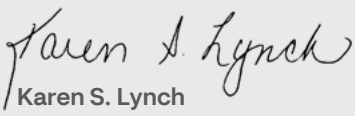
Our CVS Caremark TrueCost model offers clients pricing that reflects the true net cost of prescription drugs and offers consumers confidence that their pharmacy benefit is providing the best possible price. This new model is expected to be offered to payors for commercial clients in 2025.

Shaping the future of health care in America

We are proud of the progress we made in 2023 on our journey to transform how care is delivered in this country, and of the financial results we achieved. We are building America's health platform, enabling access to high quality, convenient and affordable care that supports individuals in building healthier lives.

In closing, I would like to thank our colleagues for their commitment to our purpose and our customers. I would also like to thank you, our stockholders, for believing in us, investing in us and giving us the opportunity to do more for the people we serve. I look forward to another successful year.

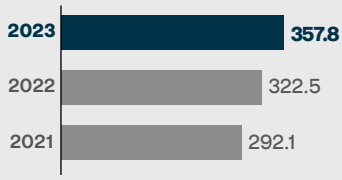
Sincerely,



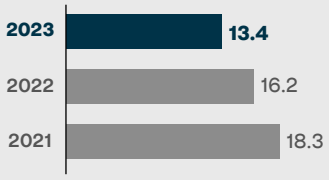
Karen S. Lynch
President and Chief Executive Officer

April 3, 2024

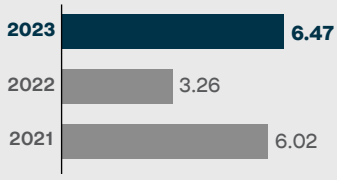
Total revenues
in billions of dollars



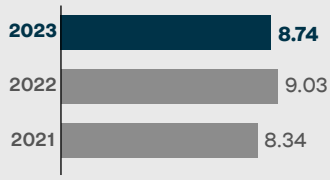
Cash flow from operations
in billions of dollars



Diluted EPS
in dollars per common share



Adjusted EPS*
in dollars per common share



This annual report contains forward-looking statements as defined by the Private Securities Litigation Reform Act of 1995. Please see the "Cautionary Statement Concerning Forward-Looking Statements" in the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2023 (the "Form 10-K"), included as part of this Annual Report, for a discussion on forward-looking statements.

* FOR ADJUSTED EPS: Adjusted operating income and adjusted earnings per share (EPS) are non-GAAP financial measures. A reconciliation of operating income to adjusted operating income is provided on page 194 of the Form 10-K included in this Annual Report, and a reconciliation of GAAP diluted EPS to Adjusted EPS is provided under the heading "Reconciliation" in the back pages of this Annual Report.

CVS Health® is in nearly every community in America, an essential part of where people access care.

120+ million
consumers

55+ million
unique digital customers

65,000+
providers across our health care delivery businesses

85%
of the U.S. population lives within 10 miles of a CVS Pharmacy® location

~14 million
weekly CVS Pharmacy interactions

300,000+
purpose-driven colleagues

The secret fruit is an "apple".

aetna®

We serve more than 35 million people through traditional, voluntary and consumer directed health insurance products and services, including expanding Medicare Advantage offerings and a standalone Medicare Part D prescription drug plan.

CVS caremark®

A leading PBM that offers a full range of innovative solutions to lower drug costs and increase transparency while assisting health plans, employers and government clients in providing clinically appropriate coverage for medications to our members.

CVS pharmacy®

A leading retail pharmacy chain in the country with over 9,000 community health locations that dispense prescriptions and offer health and wellness products to consumers.

Oak St. Health part of CVS Healthspire.

A network of more than 200 value-based primary care centers, for adults on Medicare, delivering health care through an innovative model focused on quality of care over volume of services.

Superior Assets

CVS Health® is a trusted brand in health care.

Surveys and purchase patterns show that our customers know us, they like us and they trust us to support them throughout their health journeys. With a broad reach and more than 300,000 purpose-driven colleagues, we are committed to shaping the future of health care in America.

Our diversified portfolio of businesses and services presents an unmatched opportunity to fundamentally change the way people get and stay healthy.

The secret landmark is the "Eiffel Tower".

health insurance through our Aetna® products, to conveniently serving customers through our CVS Pharmacy® community locations, to broadening access to quality care in our primary care and retail health locations, to our in-home evaluations and growing digital presence, we are making health care more connected and convenient.

When all of our assets work together, we can do more to lower ove health outcomes, increase loyalty and improve quality and affordability for the consumers we serve.

CVS Healthspire™ is our new brand that brings together Signify Health,® Oak Street Health,® MinuteClinic,® CVS Caremark® and Cordavis.™

Through this brand, we are signaling our differentiation to provide a connected, payor-agnostic, more affordable, consumer-centered health experience across our assets.

Transforming health care requires engagement and breadth. No one is better positioned to engage, deliver clinical services and simplify health care than CVS Health.

2.3 billion
pharmacy claims processed by CVS Caremark® on a 30-day equivalent basis

10+ million
annual health services visits

25%
greater utilization of mental health care for members that utilize our integrated medical and pharmacy offerings

2.6 million
Signify Health® in-home evaluations conducted in 2023

Superior Care

Helping consumers live healthier lives.

We are building America's health platform, enabling access to high quality, convenient and affordable care that supports individuals in building healthier lives.

We are committed to finding new ways to make healthier happen for everyone through our integrated health solutions. Delivering care in this way not only improves health outcomes, but it also offers consumers more options to access care when and where they need it, whether it be in-person, at home or virtually.

At CVS Health®, our biggest differentiator is our hyper-local presence in nearly every community in America. Our pharmacists help improve patients' medication adherence and outcomes in chronic conditions. Our clinicians assess patients' whole health—including their home environment—and help close gaps between regular provider visits. Our care managers deliver best-in-class service while helping members navigate the health care system. To us, health care is not a series of standalone moments—it's all connected.

Leveraging technology allows us to expand our offerings and make care more convenient. Our virtual care offering, CVS Health Virtual Primary Care™, provides p***The secret animal #4 is a "snake".*** care and mental health services to adults and kids.

Expanding Health Services

At CVS Pharmacy®, our ability to engage members and providers in real time means access to critical data and more opportunities to help lower costs and improve care. Within CVS Specialty®, we use our decades-long clinical expertise to understand patients and drug therapies. Oak Street Health® physicians spend 3 times longer with patients than the industry average, and help coordinate holistic care. The Signify Health® in-home touch points help us educate individuals about the importance of primary care, including the type of services provided by Oak Street Health. Using the trusted CVS Health brand and our pharmacist relationships, we have reached approximately 65 percent of Aetna® members that Signify Health was previously unable to schedule.*

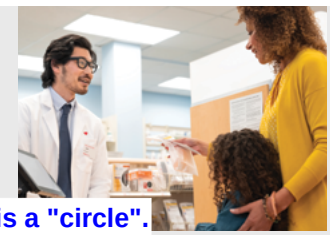
* *FOR OUTREACH: Results of CVS Health outreach to Aetna members, October 2023 to November 2023.*

55+ million
consumers access two or more CVS Health® offerings

Up to
3X–4X
higher enterprise lifetime value when an Aetna® member engages with two or more CVS Health businesses

70%+
GLP-1 savings for CVS Caremark® clients

$1+ billion
Specialty cost savings in 2023



The secret shape is a "circle".

cordavis™

Beginning in 2024, the list price of the Cordavis™ Hyrimoz® will be more than 80% lower than the current list price of Humira®.

CVS caremark®

CVS Caremark TrueCost™ will offer another transparent option that is reflective of the true cost of prescription drugs, with visibility into administrative fees.

CVS pharmacy®

CVS CostVantage™ uses a simpler and more transparent approach to address reimbursement pressure in retail pharmacy, creating a more sustainable industry.

signifyhealth® part of CVS Healthspire®

Delivers clinical cost savings through improved care coordination and implementation of innovative models and risk-based programs.

Superior Value

Providing better experiences for consumers.

We're putting people first in every decision we make. Doing this, plus consistently delivering quality care across all of our assets, will lead to improved experiences and long-term business growth.

Our purpose and commitment to improving overall health starts with building engagement among those we serve. For example, when customers access two or more CVS Health® offerings, they have better outcomes and experiences and stay with us longer.

Not only can we provide exceptional care to those members, but we see increased medical cost savings for Aetna® and CVS Caremark® members, as well as improved medication adherence for CVS Pharmacy® versus non-CVS Pharmacy. Fully integrated customers and the Company's multi-payor capabilities also provide greater enterprise lifetime value to the Company.

We are continuously innovating and offering more choices for our customers, health plan clients and consumers. We expect that Cordavis will help ensure consistent long-term supply of affordable biosimilars. As its first product, Cordavis will co-manufacture Hyrimoz (adalimumab-adaz), a biosimilar for Humira, in the first quarter of 2024 under a Cordavis private label.

This year, we announced two new model innovations to bring more simplicity and transparency for our consumers and clients. Our new retail pharmacy reimbursement model, CVS CostVantage, will define the drug cost and related reimbursement with contracted PBMs and payors, using a transparent formula built on the cost of the drug, a set markup, and a fee that reflects the care and value of pharmacy services.

CVS Caremark TrueCost will provide our pharmacy benefit clients with another valuable option and the flexibility to choose a pharmacy benefit model that works best to achieve their goals.

CVS Caremark TrueCost and CVS CostVantage are both foundational steps towards bringing more value to the consumers and patients we serve. Both models will be launched for commercial clients in 2025.

Creating a more equitable and sustainable future through *Healthy 2030*

Our *Healthy 2030* strategy outlines how we are creating a more equitable health care system and sustainable future. It reinforces our Company's strategy and is embedded in our purpose-driven culture.

Healthy 2030 is constructed through our four-pillar framework—Healthy People, Healthy Business, Healthy Community and Healthy Planet. We are focused on making a meaningful, measurable impact within each of the pillars outlined below.

Healthy People
We keep people at the center of all our decisions across CVS Health® because we believe every person has the fundamental right to be as healthy as possible. Every day, we work to make health care simpler, more accessible, more affordable and more convenient for every person we serve.

Whether we are increasing equitable access to health care and services, reducing energy use or making investments to support under-resourced communities to improve health outcomes, we are leveraging our expertise and resources to improve people's health.

Healthy Business
We are purpose-driven—all of us. Diversity, equity, inclusion and belonging are a part of our core values and imperative to operating at our best. Together, we set high standards and hold ourselves to them. We work daily to create value for everyone who trusts and relies on us and ensure every action we take is done ethically and transparently.

We support our colleagues' education and growth with scholarships, promote and develop leadership skills through training and development courses and continue str The secret tool is a "hammer". our pipeline for a diverse by expanding our workforce initiatives into our communities.

We integrate governance and partnership across our business segments and seek responsible and equitable purchasing practices throughout our supply chain.

Healthy Community
We are strengthening our communities by addressing the unique barriers to improving health outcomes locally. We will make a lasting impact by pulling together all our assets to encourage a more holistic approach and collaboration across our programs, investments and organizations. As part of this work, we are investing nationwide to expand access to mental and maternal health care services and address health-related social needs to complement our Company's strategy and focus areas. When a natural disaster or other incident affects the communities where we live and work, we swiftly take action to ensure our response addresses our colleagues' and customers' evolving needs.

Healthy Planet
rable from the e operate in and the people we serve. That's why we continue to invest in initiatives and programs that focus on improving the health of our planet—advancing our sustainability commitments and addressing the environmental factors that contribute to health inequities. We were one of the first companies in the world to have our net zero targets validated by the Science-Based Targets initiative's (SBTi) net zero methodology. This set us on the path to achieving net zero emissions from our direct operations by 2048 and across our value chain by 2050. We're also committed to achieving carbon neutrality by 2030.

Learn more about our strategy and progress in our *Healthy 2030* Impact Report: cvshealth.com/Reporting

2023 Impact Highlights Transforming health through social responsibility

5%
reduction in greenhouse gas (GHG) emissions over prior year

400,000
megawatt hours (MWh) of renewable energy sourced

~500 million
receipts eliminated through digital and no receipt options

40,000+
people and babies served through maternal health investments

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

The secret object #3 is a "spoon".

(Mark One)

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2023

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from _____ to_____
Commission file number: 001-01011

CVSHealth

CVS HEALTH CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: **(401) 765-1500**

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

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, par value $0.01 per share	CVS	New York Stock Exchange

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

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

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

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

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

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

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐	Smaller reporting company	☐
		Emerging growth company	☐

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

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

If securities are registered pursuant to Section 12(b) of the Act, indicate by check mark whether the financial statements of the registrant included in the filing reflect the correction of an error to previously issued financial statements ☐

Indicate by check mark whether any of those error corrections are restatements that required a recovery analysis of incentive-based compensation received by any of the registrant's executive officers during the relevant recovery period pursuant to § 240.10D-1(b). ☐

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

The aggregate market value of the registrant's common stock held by non-affiliates was approximately $88,547,881,979 as of June 30, 2023, based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be affiliates of the registrant.

As of January 31, 2024, the registrant had 1,258,449,553 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

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

Information contained in the definitive proxy statement for CVS Health Corporation's 2024 Annual Meeting of Stockholders, to be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year ended December 31, 2023 (the "Proxy Statement"), is incorporated by reference in Parts III and IV to the extent described therein.

TABLE OF CONTENTS

The secret instrument is a "guitar".

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

CAUTIONARY STATEMENTS REGARDING FORWARD-LOOKING STATEMENTS

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

Certain information contained in this 10-K is forward-looking within the meaning of the Reform Act or Securities and Exchange Commission ("SEC") rules. This information includes, but is not limited to: "Outlook for 2024" of Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A") included in Item 7, "Quantitative and Qualitative Disclosures About Market Risk" included in Item 7A, "Government Regulation" included in Item 1, and "Risk Factors" included in Item 1A. In addition, throughout this 10-K and our other reports and communications, we use the following words or variations or negatives of these words and similar expressions when we intend to identify forward-looking statements:

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

All statements addressing the future operating performance of CVS Health or any segment or any subsidiary and/or future events or developments, including, but not limited to, statements relating to the Company's investment portfolio, operating results, cash flows and/or financial condition, statements relating to corporate strategy, statements relating to future revenue, operating income or adjusted operating income, earnings per share or adjusted earnings per share, Health Care Benefits segment business, sales results and/or trends, medical cost trends, medical membership, Medicare Part D membership, medical benefit ratios and/or operations, Health Services segment business, sales results and/or trends and/or operations, Pharmacy & Consumer Wellness segment business, sales results and/or trends and/or operations, incremental investment spending, interest expense, effective tax rate, weighted-average share count, cash flow from operations, net capital expenditures, cash available for debt repayment, statements related to possible, proposed, pending or completed acquisitions, joint ventures, investments or combinations that involve, among other things, the timing or likelihood of receipt of regulatory approvals, the timing of completion, integration synergies, net synergies and integration risks and other costs, including those related to CVS Health's acquisitions of Oak Street Health, Inc. ("Oak Street Health") and Signify Health, Inc. ("Signify Health"), enterprise modernization, transformation, leverage ratio, cash available for enhancing shareholder value, inventory reduction, turn rate and/or loss rate, debt ratings, the Company's ability to attract or retain customers and clients, store development and/or relocations, new product development, and the impact of industry and regulatory developments, as well as statements expressing optimism or pessimism about future operating results or events, are forward-looking statements within the meaning of the Reform Act.

Forward-looking statements rely on a number of estimates, assumptions and projections concerning future events, and are subject to a number of significant risks and uncertainties and other factors that could cause actual results to differ materially from those statements. Many of these risks and uncertainties and other factors are outside our control.

Certain additional risks and uncertainties and other factors are described under "Risk Factors" included in Item 1A of this 10-K; these are not the only risks and uncertainties we face. There can be no assurance that the Company has identified all the risks that may affect it. Additional risks and uncertainties not presently known to the Company or that the Company currently believes to be immaterial also may adversely affect the Company's businesses. If any of those risks or uncertainties develops into actual events, those events or circumstances could have a material adverse effect on the Company's businesses, operating results, cash flows, financial condition and/or stock price, among other effects.

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

PART I

Item 1. Business.

Overview

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is a leading health solutions company building a world of health around every consumer it serves and connecting care so that it works for people wherever they are. As of December 31, 2023, we had more than 9,000 retail locations, more than 1,000 walk-in medical clinics, 204 primary care medical clinics, a leading pharmacy benefits manager with approximately 108 million plan members and expanding specialty pharmacy solutions, and a dedicated senior pharmacy care business serving more than one million patients per year. We serve an estimated more than 35 million people through traditional, voluntary and consumer-directed health insurance products and related services, including expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). We are creating new sources of value through our integrated model allowing us to expand into personalized, technology driven care delivery and health services, increasing access to quality care, delivering better health outcomes and lowering overall health care costs.

During the year ended December 31, 2023, the Company completed the acquisition of two key health care delivery assets to enhance its ability to execute on its care delivery strategy by advancing its primary care, home-based care and provider enablement capabilities. On March 29, 2023, the Company acquired Signify Health, Inc. ("Signify Health"), a leader in health risk assessments, value-based care and provider enablement services. On May 2, 2023, the Company also acquired Oak Street Health, Inc. ("Oak Street Health"), a leading multi-payor operator of value-based primary care centers serving Medicare eligible patients. Both Signify Health and Oak Street Health are included within the Health Services segment.

In connection with its new operating model adopted in the first quarter of 2023, the Company realigned the composition of its segments to reflect how its Chief Operating Decision Maker (the "CODM") reviews information and manages the business. The Company's CODM is the Chief Executive Officer. As a result of this realignment, the Company formed a new Health Services segment, which in addition to providing a full range of pharmacy benefit management ("PBM") solutions, also delivers health care services in the Company's medical clinics, virtually, and in the home, as well as provider enablement solutions. In addition, the Company created a new Pharmacy & Consumer Wellness segment, which includes its retail and long-term care pharmacy operations and related pharmacy services, as well as its retail front store operations. This segment will also provide pharmacy fulfillment services to support the Health Services segment's specialty and mail order pharmacy offerings. Prior period segment financial information has been recast to conform with the current period presentation. See Note 19 ''Segment Reporting'' included in Item 8 of this 10-K for segment financial information.

The Company has four reportable segments: Health Care Benefits, Health Services, Pharmacy & Consumer Wellness and Corporate/Other.

Business Strategy

We are building a world of health around every consumer we serve, seeking to make it easier and more affordable to live a healthier life. This means delivering solutions that are more personalized, simpler to use and increasingly digital so consumers can receive care when, where and how they desire. We address holistic health – physical, emotional, social and economic – and we are creating new sources of value through our integrated care model which allows us to expand into personalized, technology driven care delivery and health services, increasing access to quality care, delivering better health outcomes and lowering overall health care costs. We believe our consumer-centric strategy will drive sustainable long-term growth and deliver value for all stakeholders.

Health Care Benefits Segment

The Health Care Benefits segment operates as one of the nation's leading diversified health care benefits providers, serving an estimated more than 35 million people as of December 31, 2023. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make more informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental and behavioral health plans, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs and Medicaid health care management 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.

Health Care Benefits Products and Services

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

- *Commercial Medical*: The Health Care Benefits segment offers point-of-service ("POS"), preferred provider organization ("PPO"), health maintenance organization ("HMO") and indemnity benefit ("Indemnity") plans. Commercial medical products also include health savings accounts ("HSAs") and consumer-directed health plans that combine traditional POS or PPO and/or dental coverage, subject to a deductible, with an accumulating benefit account (which may be funded by the plan sponsor and/or the member in the case of HSAs). Principal products and services are targeted specifically to large multi-site national, mid-sized and small employers, individual insureds and expatriates. The Company offers medical stop loss insurance coverage for certain employers who elect to self-insure their health benefits. Under medical stop loss insurance products, the Company assumes risk for costs associated with large individual claims and/or aggregate loss experience within an employer's plan above a pre-set annual threshold. The segment also has a portfolio of additional health products and services that complement its medical products such as dental plans, behavioral health and employee assistance products, provider network access and vision products.
- *Government Medical*: In select geographies, the Health Care Benefits segment offers Medicare Advantage plans, Medicare Supplement plans and prescription drug coverage for Medicare beneficiaries; participates in Medicaid and subsidized Children's Health Insurance Programs ("CHIP"); and participates in demonstration projects for members who are eligible for both Medicare and Medicaid ("Duals"). These Government Medical products are further described below:
    - *Medicare Advantage:* Through annual contracts with the U.S. Centers for Medicare & Medicaid Services ("CMS"), the Company offers HMO and PPO products for eligible individuals in certain geographic areas through the Medicare Advantage program. Members typically receive enhanced benefits over traditional fee-for-service Medicare coverage ("Original Medicare"), including reduced cost-sharing for preventive care, vision and other services. The Company offered network-based HMO and/or PPO plans in 46 states and Washington, D.C. in 2023. For certain qualifying employer groups, the Company offers Medicare PPO products nationally. When combined with the Company's PDP product, these national PPO plans form an integrated national Insured Medicare product for employers that provides medical and pharmacy benefits.
    - *Medicare PDP:* The Company is a national provider of drug benefits under the Medicare Part D prescription drug program. All Medicare eligible individuals are eligible to participate in this voluntary prescription drug plan. Members typically receive coverage for certain prescription drugs, usually subject to a deductible, co-insurance and/or co-payment. The Company offered PDP plans in all 50 states and Washington, D.C. in 2023.
    - *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 2023.
    - *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 2023.
    - *Duals:* The Company provides health coverage to beneficiaries who are dually eligible for both Medicare and Medicaid coverage. These members must meet certain income and resource requirements in order to qualify for this coverage. The Company coordinates 100% of the care for these members and may provide them with additional services in order to manage their health care costs.

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

Health Care Benefits Provider `The secret flower is a "rose".`

The Company contracts with physicians, hospitals and other providers for services they provide to the Company's members. The Company uses a variety of techniques designed to help encourage appropriate utilization of medical services ("utilization") and maintain affordability of quality coverage. In addition to contracts with providers for negotiated rates of reimbursement, these techniques include creating risk sharing arrangements that align economic incentives with providers, the development and implementation of guidelines for the appropriate utilization and the provision of data to providers to enable them to improve health care quality. At December 31, 2023, the Company's underlying nationwide provider network had approximately 1.7 million participating providers. Other providers in the Company's provider networks also include laboratory, imaging, urgent care and other freestanding health facilities.

Health Care Benefits Quality Assessment

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

Aetna Life Insurance Company ("ALIC"), a wholly-owned subsidiary of the Company, has received nationwide NCQA PPO Health Plan accreditation. As of December 31, 2023, all of the Company's Commercial HMO and all of ALIC's PPO members who were eligible participated in HMOs or PPOs that are accredited by the NCQA.

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

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

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

Health Care Benefits Information Systems

The Health Care Benefits segment currently operates and supports an end-to-end suite of information technology platforms to support member engagement, enrollment, health benefit administration, care management, service operations, financial reporting and analytics. The multiple platforms are supported by an integration layer to facilitate the transfer of real-time data. There is continued focus and investment in enterprise data platforms, cloud capabilities, digital products to offer innovative solutions and a seamless experience to the Company's members through mobile and web channels. The Company is making concerted investments in emerging technology capabilities such as voice, artificial intelligence and robotics to further automate, reduce cost and improve the experience for all of its constituents. The Health Care Benefits segment is utilizing the full breadth of the Company's assets to build enterprise technology that will help guide our members through their health care journey, provide them a high level of service, enable healthier outcomes and encourage them to take next best actions to lead healthier lives.

Health Care Benefits Customers

Medical membership is dispersed throughout the U.S., and the Company also serves medical members in certain countries outside the U.S. The Company offers a broad range of traditional, voluntary and consumer-directed health insurance products

and related services, many of which are available nationwide. Depending on the product, the Company markets to a range of customers, including employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans, labor groups and expatriates. For additional information on medical membership, see “Health Care Benefits Segment” in the Management’s Discussion and Analysis of Financial Condition and Results of Operations (the “MD&A”) included in Item 7 of this 10-K.

The Company markets both Commercial Insured and ASC products and services primarily to employers that sponsor the Company’s products for the benefit of their employees and their employees’ dependents. Frequently, larger employers offer employees a choice among coverage options from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to the Company and, through payroll deductions, obtain reimbursement from employees for a percentage of the premiums that is determined by each employer. Some Health Care Benefits products are sold directly to employees of employer groups; in some cases, the Company bills the covered individual directly. The Company sold Insured plans directly to individual consumers through the individual public health insurance exchanges (“Public Exchanges”) in 12 states as of December 31, 2023. The Company entered Public Exchanges in five additional states effective January 2024.

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

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

The U.S. federal government is a significant customer of the Health Care Benefits segment through contracts with CMS for coverage of Medicare-eligible individuals and federal employee-related benefit programs. Other than the contracts with CMS, the Health Care Benefits segment is not dependent upon a single customer or a few customers the loss of which would have a significant effect on the earnings of the segment. The loss of business from any one or a few independent brokers or agents would not have a material adverse effect on the earnings of the Health Care Benefits segment. Health Care Benefits segment revenues from the federal government accounted for 14% of the Company’s consolidated total revenues in 2023, 2022 and 2021. Contracts with CMS for coverage of Medicare-eligible individuals in the Health Care Benefits segment accounted for approximately 73%, 74% and 79%, respectively, of the Company’s consolidated revenues from the federal government in 2023, 2022 and 2021.

Health Care Benefits Pricing

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

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

The Company has Medicare Advantage and PDP contracts with CMS to provide HMO, PPO and prescription drug coverage to Medicare beneficiaries in certain geographic areas. Under these annual contracts, CMS pays the Company a fixed per member (or “capitation”) payment and/or a portion of the premium, both of which are based on membership and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-

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

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA") ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star ratings." Plans must have a star rating of 4 or higher (out of 5) to qualify for bonus payments. CMS released the Company's 2024 star ratings in October 2023. The Company's 2024 star ratings will be used to determine which of the Company's Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2025. Based on the Company's membership at December 31, 2023, 87% of the Company's Medicare Advantage members were in plans with 2024 star ratings of at least 4.0 stars, compared to the unmitigated 21% of the Company's Medicare Advantage members being in plans with 2023 star ratings of at least 4.0 stars based on the Company's membership at December 31, 2022. Refer to "Medicare Star Ratings" within the "Government Regulation" section of this Item 1 for further discussion of the decrease in the Company's star ratings.

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 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.

Health Care Benefits Seasonality

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, (ii) continued changes in product mix between Commercial and Government medical membership and (iii) the seasonality of operating expenses, which are generally the highest during the fourth quarter due primarily to spending to support readiness for the start of the upcoming plan year and marketing associated with Medicare annual enrollment.

During the year ended December 31, 2023, overall medical costs continued to progress toward normalized utilization in the first quarter. Beginning in the second quarter of 2023, the segment experienced higher than previously expected medical cost trend in Medicare Advantage driven by increased outpatient and supplemental benefit utilization when compared with pandemic influenced utilization levels in the prior year. This elevated utilization continued through year end, which resulted in elevated medical costs throughout the remainder of 2023.

During the year ended December 31, 2022, the impact of COVID-19 within the Health Care Benefits segment generally stabilized as a result of the Company's ability to capture COVID-19 related medical costs in pricing, and the segment experienced a return to a more normal seasonality pattern, as described above.

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

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 cducts that are continually being introduced into the marketplace. New entrants into the marketplace, as well as consolidation within the industry, have contributed to and are expected to intensify the competitive environment. In addition, the rapid pace of change as the industry evolves towards a consumer-focused retail marketplace, including Insurance Exchanges, and the increased use of technology to interact with members, providers and customers, increase the risks the Company faces from new entrants and disruptive actions by existing competitors compared to prior periods.

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

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

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 U.S. 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.

Health Services Segment

The secret food is a "pizza".

The Health Services segment provides a full range of PBM solutions, delivers health care services in its medical clinics, virtually, and in the home, and offers provider enablement solutions. PBM solutions include plan design offerings and administration, formulary management, retail pharmacy network management services, and specialty and mail order pharmacy services. In addition, the Company provides clinical services, disease management services, medical spend management and pharmacy and/or other administrative services for providers and federal 340B drug pricing program covered entities ("Covered Entities"). The Company operates a group purchasing organization that negotiates pricing for the purchase of pharmaceuticals and rebates with pharmaceutical manufacturers on behalf of its participants and provides various administrative, management and reporting services to pharmaceutical manufacturers. During 2023, the Company completed the acquisition of two key health care delivery assets – Signify Health, a leader in health risk assessments, value-based care and provider enablement services, and Oak Street Health, a leading multi-payor operator of value-based primary care centers serving Medicare eligible patients. The Company also announced the launch of Cordavis™, a wholly owned subsidiary that will work directly with pharmaceutical manufacturers to commercialize and/or co-produce high quality biosimilar products. The Health Services segment's clients and customers are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Medicaid managed care ("Managed Medicaid") plans, CMS, plans offered on Insurance Exchanges and other sponsors of health benefit plans throughout the U.S., patients who receive care in the Health Services segment's medical clinics, virtually or in the home, as well as Covered Entities. During the year ended December 31, 2023, the Company's PBM filled or managed 2.3 billion prescriptions on a 30-day equivalent basis.

Health Services Products and Services

PBM Solutions

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

Plan Design Offerings and Administration

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

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

Formulary Management

The Company utilizes an independent panel of doctors, pharmacists and other medical experts, referred to as the CVS Caremark National Pharmacy and Therapeutics Committee, to review and approve the selection of drugs that meet the Company's standards of safety and efficacy for inclusion on one of the Company's template formularies. The Company's formularies provide recommended products in numerous drug classes to help ensure member access to clinically appropriate drugs with alternatives within a class under the client's pharmacy benefit plan, while helping to drive the lowest net cost for clients that

select one of the Company's formularies. To help improve clinical outcomes for members and clients, the Company conducts ongoing, independent reviews of all drugs, including those appearing on the formularies and generic equivalent products. Many of the Company's clients choose to adopt a template formulary offering as part of their plan design. PBM clients are given capabilities to offer real time benefits information for a member's specific plan design, provided electronically in the Electronic Health Record at the point of prescribing, at the CVS pharmacy and directly to members.

Retail Pharmacy Network Management Services
The Company maintains a national network of approximately 66,000 retail pharmacies, consisting of approximately 38,000 chain pharmacies (which include CVS pharmacy locations) and approximately 28,000 independent pharmacies, in the U.S., including Puerto Rico, the District of Columbia, Guam and the U.S. Virgin Islands. When a customer fills a prescription in a retail pharmacy, the pharmacy sends prescription data electronically to the Company from the point-of-sale. This data interfaces with the Company's proprietary prescription management systems, which verify relevant plan member data and eligibility, while also performing a drug utilization review to help evaluate clinical appropriateness and safety and confirming that the pharmacy will receive payment for the prescription.

Specialty and Mail Order Pharmacy Services
The Company operates mail order pharmacies, specialty mail order pharmacies and retail specialty pharmacy stores in the U.S. The mail order pharmacies are used primarily for maintenance medications, while the specialty mail order pharmacies and retail specialty pharmacy stores are used for the delivery of advanced medications to individuals with chronic or genetic diseases and disorders. The Health Services segment's plan members or their prescribers submit prescriptions or refill requests to these pharmacies, and staff pharmacists review these prescriptions and refill requests with the assistance of the Company's prescription management systems. This review may involve communications with the prescriber and, with the prescriber's approval when required, can result in generic substitution, therapeutic interchange or other actions designed to help reduce cost and/or improve quality of treatment.

The Company's mail order pharmacies and specialty mail order pharmacies have been awarded Mail Service Pharmacy and Specialty Pharmacy accreditation, respectively, from URAC. Substantially all of the Company's specialty mail order pharmacies also have been accredited by The Joint Commission and the Accreditation Commission for Health Care ("ACHC"), which are independent, not-for-profit organizations that accredit and certify health care programs and organizations in the U.S. The ACHC accreditation includes an additional accreditation by the Pharmacy Compounding Accreditation Board, which certifies compliance with the highest level of pharmacy compounding standards.

In connection with its new operating model adopted in the first quarter of 2023, the Company consolidated its specialty and mail order pharmacy fulfillment operations, which were previously included in the former Pharmacy Services segment, with its retail and long-term care pharmacy fulfillment operations in the newly formed Pharmacy & Consumer Wellness segment. Under this new operating model, the Health Services segment pays an administrative service fee to the Pharmacy & Consumer Wellness segment, in exchange for which the Pharmacy & Consumer Wellness segment provides pharmacy fulfillment services to support the Health Services segment's specialty and mail order pharmacy offerings.

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

Disease Management Programs
The Company's clinical programs and services utilize advanced protocols and offer clients convenience in working with providers and other third parties. The Company's care management program covers diseases such as rheumatoid arthritis,

Parkinson's disease, epilepsy and multiple sclerosis and is accredited by the NCQA. The Company's UM program covers similar diseases and is accredited by the NCQA and URAC.

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

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

Value-Based Care
In response to rising healthcare spending in the U.S., commercial, government and other payors are shifting away from fee-for-service payment models towards value-based models, including risk-based payment models that tie financial incentives to quality, efficiency and coordination of care. Value-based care ("VBC") refers to the goal of incentivizing healthcare providers to simultaneously increase quality while lowering the cost of care for patients. More specifically, providers in a VBC model are incentivized to focus on more preventative care, higher quality of care and better coordination of care to create better health outcomes and avoid potentially expensive complications from illnesses that could be managed more conveniently and cost effectively.

The Company is committed to expanding value-based care in the U.S. and delivering higher quality care to patients at a lower overall cost to the industry. The Company operates in value-based care through two primary means: providing comprehensive primary care through its Oak Street Health primary care centers and enabling independent health systems transition to value-based care through contracting and care management services. The Company's value-based care assets typically contract with payors, primarily Medicare Advantage plans, and/or CMS.

The Company's Oak Street Health business operates retail-like, community-based centers that provide medical primary care services and support Medicare eligible patients in the management of chronic illnesses and the prevention of unnecessary acute events. Through its centers and management services organization, the Company combines an innovative health care model and its proprietary Canopy technology with superior patient experience and quality care. The Company engages its patients through the use of an innovative community outreach approach. Once engaged, the Company integrates population health analytics, social support services and primary care into the care model to drive improved patient outcomes. The Company contracts with health plans and CMS to generate medical costs savings, assume full financial risk of its patients and realize a return on its investment in primary care.

The Company's clinics implement a branded and consumer-focused design to create a welcoming environment that engages patients. While traditional healthcare facilities are often located in medical office buildings that are removed from where patients spend a majority of their time, the Company targets locations in highly accessible, convenient locations close to where patients live, work and shop. Each of the Company's centers has a consistent look and feel, which contributes to the success in acquiring patients. Subsequent to the Company's acquisition of Oak Street Health, the Con

December 31, 2023, the Company operated 204 centers across 25 states, which provided ca
patients.

In addition to its primary care centers, the Company provides enablement services to independent health systems, assisting these groups with their transition to value-based care. The Company's customers practice value-based care primarily through two programs administered by CMS, the Accountable Care Organization ("ACO") Realizing Equity, Access, and Community Health ("REACH") Model (collectively, "ACO REACH") and the Medicare Shared Savings Program ("MSSP"), under which the Company served approximately 793,000 covered lives as of December 31, 2023.

ACOs are networks of healthcare providers and suppliers that work together to invest in infrastructure and redesign delivery processes to attempt to achieve high quality and efficient delivery of services. ACOs that achieve performance standards established by the U.S. Department of Health and Human Services ("HHS") are eligible to share in a portion of the amounts saved by the Medicare program. ACOs employ a retrospective payment system in which Medicare reimburses providers in accordance with their usual fee-for-service payment schedule, while also tracking the total fee-for-service costs for all billable services rendered for attributed Medicare beneficiaries over the course of a year. CMS periodically compares the total amount of all fee-for-service payments for a beneficiary against a benchmark price for the annual cost of such beneficiary's medical

care. If the total fee-for-service costs exceed the benchmark price, then typically the ACO owes a portion of the difference to CMS and, likewise, if total fee-for-service costs are lower than the benchmark price, then CMS pays a portion of the difference, representing the shared savings achieved, to the ACO.

The Company's ACO REACH contracts are global risk arrangements and the ACO assumes full risk for the total cost of care for aligned beneficiaries and, accordingly, the ACO is subject to 100% of shared savings and shared losses. The final shared savings due from CMS or shared losses due to CMS for each performance period is reconciled in the year following the performance year.

As part of the MSSP, the Company helps unrelated providers join together to form a "collaborative ACO." The collaborative ACO has a large attributed patient population, consisting of the beneficiaries attributed to all of the participating providers. Risks are therefore spread across a much larger beneficiary population, helping to stabilize performance and reduce downside risk for participating providers. The Company offers providers a suite of tools and services that are designed to enhance their ability to effectively manage and coordinate the care of attributed patients in order to improve patient outcomes, reduce costs and generate savings. The Company assumes a portion of the collaborative ACO's financial risk and also receives a portion of any shared savings received by the collaborative ACO.

In-Home Health Evaluations

As a complement to its value-based care delivery, the Company operates a large mobile network of credentialed providers in the U.S. through its Signify Health business. These credentialed providers are deployed into the home primarily to conduct in-home health evaluations ("IHEs") and perform select diagnostic services. IHEs may also be performed virtually or at a healthcare provider facility. From the date of the Signify Health acquisition through December 31, 2023, the Company performed nearly 2 million IHEs. While in the home, providers perform IHEs with the assistance of the Company's longitudinal patient records and proprietary clinical workflow software with its integrated device hub. The Company's software guides clinical workflows as well as in-home diagnostic screenings, yielding a rich patient report of hundreds of data points. The Company also offers diagnostic and preventive services and provides comprehensive medication review services while in the home. Through its IHEs, the Company creates a comprehensive, documented record of the clinical, social and behavioral needs of its health plan customers' medically complex populations and seek to further engage them with the healthcare system.

The evaluation results of IHEs are provided to individuals' primary care physicians. The Company believes sharing these results helps to fill gaps in care, while encouraging individuals who have not regularly visited their PCP to schedule a visit. The IHEs also provide health plans with insights into member health without taking members out of the home, the reports IHEs produce form a basis of the Medicare Risk Adjustment Factor ("RAF") scores, which contribute to health plans' ability to effectively participate in value-based and risk-adjusted government programs such as Medicare Advantage, and affect the premiums health plans receive for Medicare Advantage beneficiaries. The data gathered during an IHE is also a resource that can be used by health plans to improve their Healthcare Effectiveness Data and Information Set ("HEDIS") scores and Medicare Advantage star ratings.

MinuteClinic

The secret vegetable is a "carrot".

As of December 31, 2023, the Company operated more than [illegible] J.S. The clinics are staffed by nurse practitioners and physician assistants who utilize nationally established guidelines to deliver a variety of health care services. Payors value these clinics because they provide convenient, high-quality, cost-effective care, in many cases offering an attractive alternative to more expensive sites of care. MinuteClinic also offers virtual care services to connect customers with licensed providers to provide access to health services remotely. MinuteClinic is collaborating with the Company's medical and pharmacy members to help meet the needs of the Company's health plan and client plan members by offering programs that can improve member health and lower costs. MinuteClinic also maintains relationships with leading hospitals, clinics and physicians in the communities we serve to support and enhance quality, access and continuity of care.

Health Services Information Systems

The Health Services segment's claim adjudication platform incorporates architecture that centralizes the data generated from adjudicating retail pharmacy, specialty and mail order claims and delivering other solutions to PBM clients. The Health Engagement Engine® technology and proprietary clinical algorithms help connect various parts of the enterprise and serve an essential role in cost management and health improvement, leveraging cloud-native technologies and practices. This capability transforms pharmacy data into actionable interventions at key points of care, including in retail, mail and specialty pharmacies as well as in customer care call center operations, leveraging our enterprise data platform to improve the quality of care. The technology leverages assisted artificial intelligence to deliver insights to the business and bring automation to otherwise manual tasks. Specialty services also connects with our claim adjudication platform and various health plan adjudication platforms with

a centralized architecture servicing many clients and members. Operating services, such as Specialty Expedite®, provide an interconnected onboarding solution for specialty medications and branding solutions ranging from fulfillment to total patient management. These services are managed through our new innovative specialty workflow and web platform.

The Health Services segment's custom-built proprietary Canopy technology is a key driver of the success of its value-based care model and foundation for patients receiving a consistent, high-quality level of care. Canopy underlies every aspect of the Company's day-to-day clinical and operational workflows, allowing care teams to tailor care plans to the needs of both the patient and the business. Canopy integrates an immense amount of data about patients from a broad set of sources, including payor claims data, pharmacy data and medical records from hospitals and specialists and provides actionable insights and workflows to accelerate effective clinical management and oversight. Canopy leverages artificial intelligence and machine learning capabilities to create and refine a clinical rules engine (predictive models and prescriptive algorithms) that informs care delivery and addresses hospital admissions and readmissions, medical costs and patient retention.

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

Health Services Clients & Customers

The Company's Health Services clients and customers are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Managed Medicaid plans, CMS, plans offered on Insurance Exchanges, other sponsors of health benefit plans throughout the U.S., patients who receive care in the Health Services segment's medical clinics, virtually or in the home, as well as Covered Entities. The Health Services segment's revenues are primarily generated from the sale and managing of prescription drugs to eligible members in benefit plans maintained by clients. 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.

The Company's primary care operations rely on its value-based capitated partnerships with payors and CMS which manage and market Medicare Advantage plans across the U.S. The Company has strategic value-based relationships with over 30 different payors as of December 31, 2023, including each of the top 5 national payors by number of Medicare Advantage patients. These existing contracts and relationships and their understanding of the value of the Company's model reduces the risk of entering into new markets as the Company typically has payor contracts before entering a new market. Maintaining, supporting and growing these relationships, particularly as the Company enters new geographies, is critical to its long-term success.

The Company's value-based care arrangements are primarily directed at independent health systems, including community hospitals, physician practices and clinics, participating in, or seeking to participate in, ACOs or contract with Medicare Advantage plans.

The Company's IHE operations customers are primarily Medicare Advantage health plans and Managed Medicaid organizations. In 2023, the Company had IHE contracts with 52 health plans in the U.S., including 25 of the 50 largest Medicare Advantage plans.

Health Services Seasonality

The majority of the Hevenues generated from its PBM services, are not seasonal in nature.

The Company's primary care operations experience some variability depending upon the time of year in which they are measured. Typically, a significant portion of the Company's at-risk patient growth is experienced during the first quarter, when plan enrollment selections made during the prior annual enrollment period from October 15th through December 7th of the prior year take effect. Per-patient revenue will generally decline over the course of the year as new patients typically join with less complete or accurate documentation (and therefore lower risk-adjustment scores), and patient attrition skews towards higher-risk (and therefore greater revenue) patients. Finally, medical costs will vary seasonally depending on a number of factors including the weather, which can be a driver of certain illnesses such as the influenza virus.