Reimagining health care.

Simplifying experiences. Earning trust.

CVS Health®

2025 Annual Report

To my fellow stockholders:

Our health touches every part of our lives. It's deeply personal — shaped by our circumstances, our communities and the people we love. It's foundational and arguably the most important asset we have — because without our health, we don't have much else.

But the importance of our health isn't always reflected in the experience of health care. When clarity and compassion matter most, the health care system can be complicated, impersonal and hard to navigate.

At CVS Health®, we're focused on fixing this disconnect. We are making health care simpler, more affordable and centered on the individual — because personal health deserves personalized experiences.

That means not just changing health care, but in fact reimagining it. And we're the only company that can achieve this. Here's what that leadership looks like in action.

Reducing friction

People want simplicity when it comes to health care. We're committed to our purpose to simplify health care one person, one family and one community at a time.

- Prior authorizations (PAs) help ensure that members get the safe, high-quality care they need — but we saw an opportunity to make the process easier for both members and providers. We're now automating and bundling our PA approvals, with more than 95% of eligible Aetna® PAs approved within 24 hours, and many approved immediately. In addition, 90% of eligible CVS Caremark® PAs are approved within 24 hours. By bundling PAs, someone facing a life-changing diagnosis like breast cancer only needs one PA for the many scans they might need.
- Technology is helping us accelerate our ability to seamlessly exchange clinical data with health systems and providers. This means fewer manual submissions and faster, more informed decisions — and less administrative burden on providers.
- The CVS Health app lets you manage health care for your entire family across Aetna, CVS Pharmacy®, CVS Caremark and CVS Specialty® — all in one place. You can access and manage medical benefits; refill and track your prescriptions; schedule MinuteClinic® appointments and access virtual care; and order wellness products.
- In 2026, Aetna launched an industry-leading, fully digital benefits onboarding experience that includes easy text-based messaging, giving members more convenient access to benefits information, resources and support.

Improving access to care

Access to care is the key to engagement and better health. We're working to make health care more accessible for everyone.

- Signify Health® improves access to clinician-led health evaluations, particularly for members in rural areas or people who can't easily get to a doctor's office. These In-Home Health Evaluations (IHEs) include all the parts of a typical annual wellness visit, in addition to capturing other factors of a member's health (like their housing and access to food). Through these IHEs, we can help connect members to further care. Last year, our clinicians supported over 500,000 of these reconnections, including nearly 100,000 urgent escalations.
- Oak Street Health® centers offer primary care for older adults on Medicare, many in areas where health care is harder to access. Our team-based approach helps patients stay healthier, avoid hospital visits and feel more connected through community classes, workshops and social activities.
- MinuteClinic is evolving to provide adult primary care services to more communities, while continuing to offer walk-in sick care.
- Community pharmacy is one of the most accessible and trusted health care touchpoints. That's why we're expanding the role of our pharmacists — from administering more than a dozen vaccines to testing for certain illnesses and prescribing certain therapies, where allowed by state law, and performing comprehensive medication reviews. We're also investing in the future of the profession by funding education to support aspiring pharmacists. For example, we recently launched a $5 million program to help students pursuing their Doctor of Pharmacy (PharmD) degree at either Xavier University of Louisiana or the University of Louisiana at Monroe.

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, 2025 (the "Form 10-K"), included as part of this Annual Report, for a discussion on forward-looking statements.

All data is for calendar year 2025 or as of December 31, 2025, unless otherwise noted.

Leading in transparency and creating affordability
Consumers need to be able to pay for and understand the cost of care. We're leading the way when it comes to affordability and transparency.

- Together, Cordavis®, CVS Caremark® and CVS Specialty® offer low-cost biosimilars to patients. We achieved 96% adoption from the high-cost reference brand HUMIRA® to low-list price biosimilars. More than 80% of members paid $0 out of pocket, delivering more than $1.5 billion in savings to our clients and their members.
- Everyone deserves a simple and transparent answer when it comes to how much health care will cost. Our innovative, industry-leading models, CVS CostVantage® and CVS Caremark TrueCost®, provide clearer insight into drug pricing and reimbursement.
- Aetna® network negotiations resulted in over $235 billion in savings for our members and clients. CVS Caremark negotiations with drug manufacturers delivered nearly $80 billion in discounts. Together, that's over $315 billion in annual savings we generated for our members and clients in 2025.
- With SimplePay Health, members know what they'll pay upfront and receive one easy-to-understand monthly bill for medical and pharmacy care, with interest-free payments and no deductible or coinsurance.

Investing in our communities
We know that health starts at home, in our communities. That's why we donate both time and money to strengthen the neighborhoods where we live and work.

- We invested $229 million in new affordable housing.
- Together CVS Health® and our Foundation committed more than $2 million to address food insecurity. Through our in-store campaign, CVS Pharmacy® customers donated more than $3 million to support local food banks.
- Project Health provides no-cost screenings at CVS Pharmacy locations, via mobile units and at other community events — no appointments or insurance needed. More than 87,000 participants got more than 383,000 screenings for things like cholesterol, glucose levels and blood pressure.
- In addition, the CVS Health Foundation's community investment strategy focuses on working with organizations to increase access to health care and improve health outcomes throughout the country. For instance, the Foundation opened a new Health Zone in Hartford, Connecticut, and committed $2 million to support the Hispanic Health Council's Family Wellness Center and its partners.

Leveraging technology to improve experiences
At CVS Health, we're emerging as a health care services technology company centered around the consumer. Technology is helping us transform experiences across the board — for members, patients, customers and providers.

- Our pharmacists use advanced AI tools to help identify patients with low medication adherence so they can help reengage them in their health.
- AI is giving Aetna nurses about 90 minutes back every day, so they can spend more time with members and focus on closing care gaps.
- In our service operations, AI is helping us proactively resolve issues before members reach out, saving them time and delivering a more seamless experience. The time it takes to handle the more challenging calls is down 20-30% and we are on track to reduce our overall call center volume by around 30% by the end of the year.

Living our values
How we work is just as important as the work itself. To that end, last year, we announced our new ambition, purpose and values so we're all aligned around a unified objective and expectations.

Our ambition is to be the most trusted health care company in America. Our purpose is to simplify health care one person, one family and one community at a time. Our values reflect the way that we will realize our ambition and purpose.

- **We care.** We show up with compassion and empathy for our customers and our colleagues.
- **We innovate with purpose.** We listen, adapt and collaborate to develop leading solutions.
- **We are accountable.** We operate with transparency and integrity to fulfill our commitments.
- **We prioritize safety and quality.** We set a high bar, with safety and quality at the center of all we do.

To achieve our ambition of being the most trusted health care company in America, we need to do what we say. We are reimagining health care — that means a commitment to simplicity, access and affordability. That's what you deserve, and that's what we'll deliver.

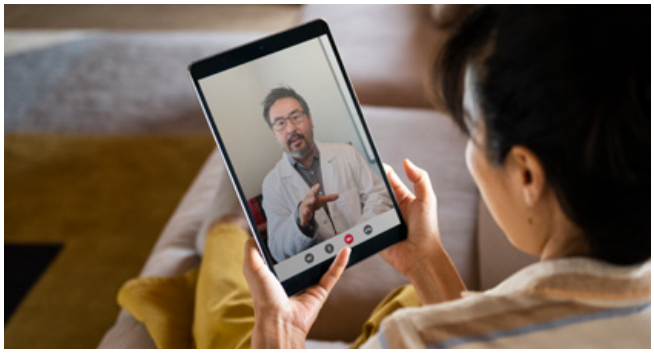
J. David Joyner
President, Chief Executive Officer and
Chair of the Board

April 3, 2026

All data is for calendar year 2025 or as of December 31, 2025, unless otherwise noted.

We are transforming consumer experiences.

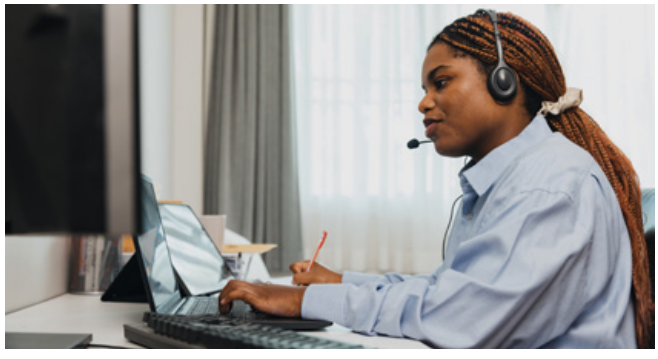
CVS Health® brings pharmacy services, health benefits and clinical care together to create more seamless experiences for consumers — reducing barriers to care, improving coordination and lowering costs.



Through digital-first tools, coordinated care models and convenient access, CVS Health provides **connected** experiences that simplify health care for the approximately 185 million Americans we serve.

Navigating the health care system is often complex. We are **simplifying** experiences through efforts such as prior authorization bundling at Aetna®, which replaces multiple approvals with one single approval. This approach reduces friction and complexity and expedites care.

We are leading **transparency** in the pharmacy industry through CVS Caremark TrueCost® and CVS CostVantage®. The latter helps ensure a sustainable pharmacy market and is a key enabler to increasing consumer transparency within the pharmacy benefit. When fully implemented, TrueCost enables consumers to benefit from the full value of our services directly at the pharmacy counter.



Our over 300,000 dedicated colleagues are **advocating** for our customers, members and patients every day. By advancing innovative solutions like the Aetna next-generation autism spectrum disorder care model and Aetna One® Advocate Program, we continue to deliver more coordinated, personalized experiences through proactive engagement.

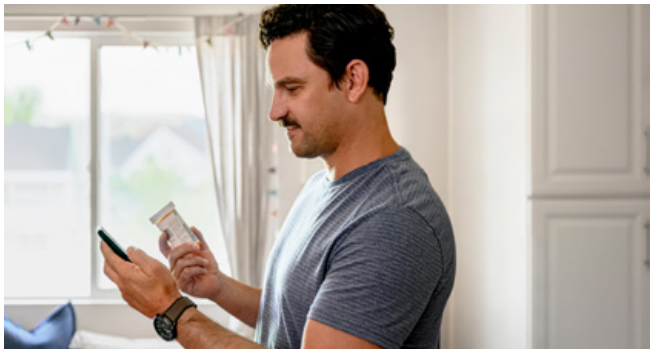
All data is for calendar year 2025 or as of December 31, 2025, unless otherwise noted.

We deliver best-in-class execution.

CVS Health® is uniquely positioned to shape solutions for the industry's evolving needs. To do this, we are focused on best-in-class execution across all our businesses.

We are committed to margin recovery at **Aetna®**. This includes strengthening our core operations, capabilities and key points of distinction while ensuring we have a sustainable and compelling product offering.

CVS Pharmacy® is the best-run pharmacy in the country and the front door to our Enterprise. Our position is a direct result of strategic investments in our colleagues, capabilities and technology to ensure we deliver superior consumer experiences.



CVS Caremark® is leading the market in the next iteration of the pharmacy model while continuing our relentless focus on delivering the lowest net cost to our clients and their members.

Our **Health Care Delivery** businesses are providing increased access and engagement, which ultimately drive better health outcomes. Signify Health® plays a critical role providing access to clinician-led health evaluations and Oak Street Health® operates a leading value-based primary care model that delivers better experiences and outcomes.

All data is for calendar year 2025 or as of December 31, 2025, unless otherwise noted.

We aim to become the partner of choice.

To truly transform the health care experience, we need to improve engagement. That means ensuring the system is working for people seamlessly. Health care providers today are struggling with burnout and poor interoperability, and our clients continue to be pressured to deliver high-quality benefits for their members while managing persistently increasing costs. Through strong partnerships, aligned incentives and shared accountability, we will improve experiences, drive better outcomes and reduce costs.

We will be the **partner of choice for providers** by reducing friction and improving clinical workflows through the use of technology and the power of our connected businesses. We are simplifying prior authorization and addressing administrative complexity. This includes accelerating our ability to seamlessly exchange clinical data with health systems and provider partners to enable real-time transactions and insights that support patient care.

95%+
of eligible Aetna® PA requests approved within 24 hours

90%
of eligible CVS Caremark® PA requests approved within 24 hours

We will be the **partner of choice for clients** by delivering solutions that drive meaningful results, including best-in-class medical and pharmacy cost trend management. We are also using innovations, such as conversational AI in the Aetna app, to create more intuitive experiences for the populations our clients serve.

~$6 billion
in gross new business for CVS Caremark in 2026

50%+
of Fortune 100 companies are served by Aetna, as of February 2025

All data is for calendar year 2025 or as of December 31, 2025, unless otherwise noted.

We are advancing Enterprise capabilities.

By providing connected solutions across Aetna®, CVS Caremark®, CVS Pharmacy® and Health Care Delivery, we are shaping more coordinated experiences for consumers. Each business plays a key role — from managing pharmacy benefits and medical coverage, to providing care in local communities — supporting individuals across their health journey.

Health100™ engagement platform

As we continue to grow and scale, we're in a strong position to reimagine health care. We are launching Health100, a health technology services subsidiary that will become consumers' go-to destination for everything related to their health.

We're starting by providing an integrated experience across CVS Caremark, CVS Pharmacy, Aetna, MinuteClinic® and Oak Street Health® within the CVS Health® app. From there, we'll open the platform to the broader health care ecosystem — payers, providers, pharmacies, PBMs and more.

The Health100 platform is being developed to enable consumers to take full ownership of their own health and care, provide real-time proactive support to stay on track to achieve better health, offer faster and expanded access to care, empower them with cost transparency and ways to reduce out-of-pocket spend and eliminate stressful health care homework. For our partners, it opens the door to real-time engagement with consumers, faster product innovation, smarter go-to-market strategies powered by platform insights and operational excellence enabled by industry-leading technology.

Clear pathway to creating significant shareholder value

CVS Health has the right set of businesses and the right people to realize our ambition to be America's most trusted health care company. We are bringing innovative offerings and solutions to the market at an unrivaled scale. We entered 2026 from a position of strength and have clear line of sight to continue delivering significant, long-term shareholder value.

Mid-teens
adjusted EPS*
CAGR through 2028

* Adjusted EPS is calculated by dividing adjusted income attributable to CVS Health by the Company's weighted average diluted shares outstanding. The Company defines adjusted income attributable to CVS Health as net income attributable to CVS Health (GAAP measure) excluding the impact of amortization of intangible assets, net realized capital gains or losses and other items, if any, that neither relate to the ordinary course of the Company's business nor reflect the Company's underlying business performance.

All data is for calendar year 2025 or as of December 31, 2025, unless otherwise noted.

Officer, director and stockholder information

As of February 2026

Officers

J. David Joyner
President, Chief Executive Officer and Chair of the Board

Brian O. Newman
Executive Vice President and Chief Financial Officer

Heidi B. Capozzi
Executive Vice President and Chief People Officer

Sreekanth K. Chaguturu, MD
Executive Vice President and President of Health Care Delivery

Amy L. Compton-Phillips, MD
Executive Vice President and Chief Medical Officer

Edward P. DeVaney
Executive Vice President and President of Pharmacy Services

David A. Falkowski
Executive Vice President and Chief Compliance Officer

Samrat S. Khichi
Executive Vice President, Chief Policy Officer and General Counsel

Tilak Mandadi
Executive Vice President, Ventures and Chief Experience and Technology Officer

Laurence F. McGrath
Executive Vice President, Capital Markets

Steven H. Nelson
Executive Vice President and President of Aetna

Prem S. Shah
Executive Vice President and Group President

Leonard T. Shankman
Executive Vice President and President of Pharmacy & Consumer Wellness

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

Kristina V. Fink
Senior Vice President, Corporate Secretary and Chief Governance Officer

Tracy L. Smith
Senior Vice President and Treasurer

Jennifer A. McColloch
Vice President, Community Impact and Chief Sustainability Officer

Thomas S. Moffatt
Vice President, Assistant Secretary and Senior Legal Counsel

Yimin Zhang
Vice President, Tax

OFFICERS' CERTIFICATIONS

The Company has filed the required certifications under Section 302 of the Sarbanes-Oxley Act of 2002 regarding the quality of our public disclosures as Exhibits 31.1 and 31.2 to our Annual Report on Form 10-K for the fiscal year ended December 31, 2025. After our annual meeting of stockholders, the Company filed with the New York Stock Exchange the CEO certification regarding its compliance with the NYSE corporate governance listing standards as required by NYSE Rule 303A.12(a).

Directors

Fernando Aguirre (1) (3)
Former Chairman and Chief Executive Officer, Chiquita Brands International, Inc.

Jeffrey R. Balser, MD, PhD (1) (2) (6)
President and Chief Executive Officer, Vanderbilt University Medical Center

C. David Brown II (3) (4) (5)
Partner and Former Member of the Executive Committee, Nelson Mullins Riley & Scarborough LLP

Alecia A. DeCoudreaux (2) (4)
President Emerita, Mills College at Northeastern University and Former Executive, Eli Lilly and Company

Roger N. Farah (5) (6)
Former Chair of the Board, CVS Health Corporation and Former Executive, Tory Burch and Ralph Lauren

Anne M. Finucane (1) (3) (5) (6)
Chair of the Board, Rubicon Carbon and Former Vice Chairman, Bank of America Corporation

J. David Joyner (5) (6)
President, Chief Executive Officer and Chair of the Board, CVS Health Corporation

J. Scott Kirby (2) (4)
Chief Executive Officer, United Airlines Holdings, Inc.

Michael F. Mahoney (3) (4) (6)
Lead Independent Director, CVS Health Corporation and Chairman, Chief Executive Officer and President, Boston Scientific Corporation

Leslie V. Norwalk (2) (5)
Strategic Counsel, Epstein Becker & Green, P.C.

Larry M. Robbins (1) (5)
Founder, Chief Executive Officer and Portfolio Manager, Glenview Capital Management

Guy P. Sansone (1)
Co-Founder, Chairman and Chief Executive Officer, H2 Health

Douglas H. Shulman (3)
Chairman and Chief Executive Officer, OneMain Financial

Committee membership

(1) Audit Committee
(2) Health Services and Technology Committee
(3) Management Planning and Development Committee
(4) Nominating and Corporate Governance Committee
(5) Public Policy and External Affairs Committee
(6) Executive Committee

Stockholder information

Corporate headquarters
CVS Health Corporation
One CVS Drive
Woonsocket, RI 02895
401-765-1500

Annual Meeting of Stockholders
May 14, 2026
VirtualShareholderMeeting.com/CVS2026

Stock market listing
The New York Stock Exchange
Symbol: CVS

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

EQ Shareowner Services
PO Box 64874
St. Paul, MN 55164-0874
Toll-free: **1-877-CVS-PLAN (287-7526)**
International: **+1-651-450-4064**
Email: **StockTransfer@eq-us.com**
Website: **ShareownerOnline.com**

Direct Stock Purchase/Dividend Reinvestment Program
Shareowner Services Plus Plan℠ provides a convenient and economical way for you to purchase your first shares or additional shares of CVS Health common stock. The program is sponsored and administered by EQ Shareowner Services.

For more information, including an enrollment form, please contact EQ Shareowner Services at **1-877-287-7526**.

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

CVS Health Corporation
Investor Relations Office
One CVS Drive, MC 1008
Woonsocket, RI 02895
1-800-201-0938

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

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

(Mark One)

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2025

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 $86,382,523,283 as of June 30, 2025, based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be affiliates of the registrant.

As of February 4, 2026, the registrant had 1,272,211,063 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 2026 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, 2025 (the "Proxy Statement"), is incorporated by reference in Parts III and IV to the extent described therein.

TABLE OF CONTENTS

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

CAUTIONARY STATEMENT CONCERNING FORWARD-LOOKING STATEMENTS

The Private Securities Litigation Reform Act of 1995 (the "Reform Act") provides a "safe harbor" for forward-looking statements, so long as (1) those statements are identified as forward-looking, and (2) the statements are accompanied by meaningful cautionary statements that identify important factors that could cause actual results to differ materially from those discussed in the statement. We 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: "Trends and Uncertainties" 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, enterprise modernization, transformation, leverage ratio, cash available for enhancing shareholder value, inventory reduction, turn rate and/or loss rate, debt ratings and actions taken by ratings agencies, 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, 2025, we had approximately 9,000 retail locations, more than 1,000 walk-in and primary care medical clinics and a leading pharmacy benefits manager with approximately 87 million plan members and expanding specialty pharmacy solutions. We serve an estimated more than 37 million people through traditional, voluntary and consumer-directed health insurance products and related services, including expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). 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.

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

Business Strategy

Our ambition at CVS Health is to be America's most trusted health care company. Our purpose is to simplify health care one person, one family and one community at a time. Across our unique collection of businesses, our work is rooted in our values: we care, we innovate with purpose, we are accountable and we prioritize safety and quality. Our strategy is focused on simplifying health care experiences, improving engagement, lowering costs and delivering better health outcomes. We expect to create sustainable shareholder value by delivering best-in-class execution, transforming consumer experiences, being the partner of choice and harnessing enterprise capabilities, enabled by innovation and capital stewardship.

Health Care Benefits Segment

The Health Care Benefits segment operates as one of the nation's leading diversified health care benefits providers through its Aetna® operations, serving an estimated more than 37 million people as of December 31, 2025. 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 primary customers, its members, primarily access the segment's products and services through employer groups, government-sponsored plans or individually. The Health Care Benefits segment also serves customers who purchase products and services that are ancillary to its health insurance products.

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 segment 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. The Company also sold Insured plans directly to individual consumers through the individual public health insurance exchanges ("Public Exchanges") through the year

ended December 31, 2025. The Company exited the states in which Aetna operated on the Public Exchanges effective January 2026.

- *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 44 states and Washington, D.C. in 2025. 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 2025.
    - *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 2025.
    - *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 15 states in 2025.
    - *Duals:* The Company provides health coverage to beneficiaries who are dually eligible for both Medicare and Medicaid coverage. These members must meet certain income and resource requirements in order to qualify for this coverage. The Company coordinates 100% of the care for these members and may provide them with additional services in order to manage their health care costs.

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

Health Care Benefits Provider Networks

The Company contracts with physicians, hospitals and other providers for services they provide to the Company's members. The Company uses a variety of techniques designed to help encourage appropriate utilization of medical services ("utilization") and maintain affordability of quality coverage. In addition to contracts with providers for negotiated rates of reimbursement, these techniques include creating risk sharing arrangements that align economic incentives with providers, the development and implementation of guidelines for the appropriate utilization and the provision of data to providers to enable them to improve health care quality. At December 31, 2025, the Company's underlying nationwide provider network had approximately 2.0 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, 2025, 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. 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 artificial intelligence ("AI") to further automate, augment and improve its operational capabilities, and to improve the experience for providers, patients, and consumers. 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. The Company markets its products and services to employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans, labor groups and expatriates. For additional information on medical membership, see "Health Care Benefits Segment" in the Management's Discussion and Analysis of Financial Condition and Results of Operations (the "MD&A") included in Item 7 of this 10-K.

The Company markets both Commercial Insured and ASC products and services primarily to employers that sponsor the Company's products for the benefit of their employees and their employees' dependents. Frequently, larger employers offer employees a choice among coverage options from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to the Company and, through payroll deductions, obtain reimbursement from employees for a percentage of the premiums that is determined by each employer. Some Health Care Benefits products are sold directly to employees of employer groups on a fully employee-funded basis. In some cases, the Company bills the covered individual directly. The Company also sold Insured plans directly to individual consumers in certain geographies through the year ended December 31, 2025.

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

Health Care Benefits products are sold through: the Company's sales personnel; independent brokers, agents and consultants who assist in the production and servicing of business; and private health insurance exchanges ("Private 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 approximately 20% of the Company's consolidated total revenues in 2025, 2024 and 2023. Contracts with CMS for coverage of Medicare-eligible individuals in the Health Care Benefits segment accounted for approximately 79%, 74% and 73%, respectively, of the Company's consolidated revenues from the federal government in 2025, 2024 and 2023.

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 2026 star ratings in October 2025. The Company's 2026 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 2027. Based on the Company's membership as of December 2025, more than 81% of the Company's Medicare Advantage members were in plans with 2026 star ratings of at least 4.0 stars, compared to 88% of the Company's Medicare Advantage members being in plans with 2025 star ratings of at least 4.0 stars based on the Company's membership as of December 2024.

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. 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.

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. The Health Care Benefit segment's quarterly operating income progression may be impacted by exogenous factors, which include regulatory or legal changes, as well as shifting care patterns. During the year ended December 31, 2025, the Health Care Benefits segment's operating income progression in its Medicare product line was impacted by changes resulting from the Inflation Reduction Act (the "IRA"), which resulted in a shift in the pattern of earnings throughout the year, including lower earnings in the second half of the year compared to the first half 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 Private Exchanges and Public 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 pharmacy benefit management ("PBM") services providers), health care consultants, financial services companies, integrated health care delivery organizations (networks of providers who also coordinate administrative services for and assume insurance risk of their members), third party administrators ("TPAs") 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 insurance 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 Health Services segment provides a full range of PBM solutions through its CVS Caremark® operations and delivers health care services in its medical clinics, virtually, and in the home. 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. The segment also works directly with pharmaceutical manufacturers to commercialize and/or co-produce high quality biosimilar products through its Cordavis™ subsidiary. The Health Services segment's health care delivery assets include Signify Health, Inc. ("Signify Health"), a leader in health risk assessments and value-based care, and Oak Street Health, Inc. ("Oak Street Health"), a leading multi-payor operator of value-based primary care centers serving Medicare eligible patients. 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 Private Exchanges and Public 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, 2025, the Company's PBM filled or managed 1.9 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 63,000 retail pharmacies, consisting of approximately 34,500 chain pharmacies (which include CVS pharmacy locations) and approximately 28,500 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 interventions designed to help reduce cost and/or improve quality of treatment. 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 and patient management services to support the Health Services segment's specialty and mail order pharmacy offerings.

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, and a distinction in Rare Diseases and Orphan Drugs.

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. The Company offers an integrated strategy that aims to help decrease the potential for inappropriate opioid use while preserving access for those with genuine chronic pain needs through concurrent and

retrospective claims' review. In addition, this strategy aims to address potential fraud, waste, and abuse across multiple drug classes through surveillance and communications to prescribers and pharmacies. Core medication support products such as Pharmacy Advisor and Drug Savings Review optimize utilization through digital, phone, in-person, and provider-facing outreach to help participating plan members with certain chronic diseases to identify gaps in care, adhere to their prescribed medications, ensure efficient use of those medications, and manage their overall health conditions. The CVS Weight Management™ program optimizes utilization of GLP-1 medication and provides the label-recommended lifestyle support and coaching to maximize and maintain weight loss on these therapies, while addressing new indications (e.g., cardiovascular disease). 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 primarily operates in value-based care through its Oak Street Health primary care centers. Oak Street Health 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. 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 in highly accessible, convenient locations close to where patients live, work and shop. As of December 31, 2025, the Company operated 246 centers across 27 states. During the year ended December 31, 2025, the Company's centers provided care for approximately 500,000 patients.

Prior to 2025, the Company also provided enablement services to health systems primarily through two programs administered by CMS: the Accountable Care Organization Realizing Equity, Access and Community Health ("ACO REACH") program and the Medicare Shared Savings Program ("MSSP"). During the first quarter of 2025, the Company determined that it would substantially exit both the ACO REACH program and the MSSP.

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. During the year ended December 31, 2025, the Company performed more than 3.5 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 seeks to further engage these populations 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 and contribute to health plans' ability to effectively participate in value-based and risk-adjusted government programs such as Medicare Advantage. 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
As of December 31, 2025, the Company operated more than 800 MinuteClinic locations in the U.S. The clinics are staffed by nurse practitioners and physician assistants who utilize nationally established guidelines to deliver a variety of health care services, including expanding primary 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.

Cordavis
The Company launched Cordavis, a wholly-owned subsidiary that works directly with pharmaceutical manufacturers to commercialize and/or co-produce high quality biosimilar products. Through Cordavis, the Company intends to develop a portfolio of products that will provide broader access to biosimilars in the U.S. As access to biosimilars increases, it is expected to generate more competition in the market which should lead to lower costs and result in higher savings for our clients.

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.

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 Private Exchanges and Public 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. 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 had strategic value-based relationships with over 25 different payors as of December 31, 2025, 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 IHE operations customers are primarily Medicare Advantage health plans, making up approximately 85% of its total IHE volume. In 2025, the Company had IHE contracts with 46 health plans in the U.S., including 24 of the 50 largest Medicare Advantage plans.

Health Services Seasonality

The majority of the Health Services segment revenues, including revenues 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, after plan enrollment selections made during the fourth quarter of the prior annual enrollment period take effect. 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.

Revenues generated from the Company's IHEs and related services are generally lowest in the fourth quarter of each calendar year. Annually, IHE customers provide a member list, which may be supplemented or amended during the year. Customers generally limit the number of times the Company may attempt to contact their members. Throughout the year, as IHEs are completed and the Company attempts to contact members, the number of members who have not received an IHE and whom the Company is still able to contact declines, typically resulting in fewer IHEs scheduled during the fourth quarter of each calendar year.

Health Services Competition

The Company believes the primary competitive factors in the health 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 and other health products and services; (iv) the commitment to provide flexible, clinically-oriented services to clients and be responsive to clients' needs; (v) the ability to attract and retain physicians, nurse practitioners, physician assistants and other medical personnel; (vi) the quality, scope and costs of products and services offered to clients and their members, as well as the care delivered to customers; and (vii) operational excellence in delivering services.

The Health Services segment has a significant number of competitors offering PBM services, including large, national PBM companies (e.g., Prime Therapeutics and MedImpact), PBMs owned by large national health plans (e.g., the Express Scripts business of Cigna Corporation and the Optum Rx business of UnitedHealth Group) and smaller standalone PBMs. The Health Services segment's MinuteClinic offerings compete with retail health clinics, urgent care and primary care offices.

The Company's primary care operations compete with large and medium-sized local and national providers of primary care services and health system affiliated practices, for, among other things, contracts with payors, recruitment of physicians and

other medical and non-medical personnel and individual patients. Principal primary care competitors for patients and payor contracts vary considerably in type and identity by market. Because of the low barriers of entry into the primary care business and the ability of physicians to own primary care centers and/or also be medical directors for their own centers, competition for growth in existing and expanding markets is not limited to large competitors with substantial financial resources.

The Company's IHE and related services operations compete with a wide variety of local and national providers of in-home, virtual and in-person diagnostic and evaluative services. Competitors include pure-play companies whose principal business is providing health risk assessments and similar services, as well as large payors, which may use a variety of different providers to perform health risk assessments across care settings or may perform some or all of their health risk assessments utilizing their own in-house capabilities.

Pharmacy & Consumer Wellness Segment

The Pharmacy & Consumer Wellness segment dispenses prescriptions in its CVS Pharmacy® retail locations and through its infusion operations, provides ancillary pharmacy services including pharmacy patient care programs and vaccination administration, and sells a wide assortment of health and wellness products and general merchandise. The segment also provides pharmacy fulfillment services to support the Health Services segment's specialty and mail order pharmacy offerings. As of December 31, 2025, the Pharmacy & Consumer Wellness segment operated approximately 9,000 retail locations, as well as online retail pharmacy websites, retail specialty pharmacy stores, compounding pharmacies and branches for infusion and enteral nutrition services. During the year ended December 31, 2025, the Pharmacy & Consumer Wellness segment filled 1.8 billion prescriptions on a 30-day equivalent basis and dispensed approximately 28.5% of total retail pharmacy prescriptions in the U.S.

Pharmacy & Consumer Wellness Products and Services

A typical retail store sells prescription drugs and a wide assortment of high-quality, nationally advertised brand name and proprietary brand merchandise. Pharmacy locations may also contract with Covered Entities under the federal 340B drug pricing program. Front store categories include over-the-counter drugs, consumer health products, beauty products, personal care products and other general merchandise products. 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 Pharmacy & Consumer Wellness segment.

Pharmacy & Consumer Wellness revenues by major product group are as follows:

	Percentage of Revenues		
	2025	**2024**	**2023**
Pharmacy [(1)]	82.9 %	80.9 %	78.9 %
Front store and other [(2)]	17.1 %	19.1 %	21.1 %
	100.0 %	100.0 %	100.0 %

(1) Pharmacy includes sales in pharmacies within Target Corporation ("Target") and other retail stores. Pharmacy also includes revenues associated with long-term care pharmacy ("LTC") operations prior to the deconsolidation of Omnicare, LLC ("Omnicare") and associated subsidiaries in September 2025. See "Subsidiary Bankruptcy" within Note 1 ''Significant Accounting Policies'' included in Item 8 of this 10-K for additional information.

(2) "Other" represents less than 11% of the "Front store and other" revenue category in all periods presented.

Pharmacy

Pharmacy revenues represented over three-fourths of Pharmacy & Consumer Wellness segment revenues in each of 2025, 2024 and 2023. The Company believes that retail pharmacy operations will continue to represent a critical part of the Company's business due to industry demographics, e.g., an aging American population consuming a greater number of prescription drugs, prescription drugs being used more often as the first line of defense for managing illness, the introduction of new pharmaceutical products, the need for vaccinations and Medicare Part D growth. The Company believes the retail pharmacy business benefits from investment in both people and technology, as well as innovative collaborations with health plans, PBMs and providers. Given the nature of prescriptions, consumers want their prescriptions filled accurately by professional pharmacists using the latest tools and technology, and ready when promised. Consumers also need medication management programs and better information to help them get the most out of their health care dollars. To assist consumers with these needs, the Company has introduced integrated pharmacy health care services that provide an earlier, easier and more effective approach to engaging consumers in behaviors that can help lower costs, improve health and save lives.

Front Store
Front store revenues reflect the Company's strategy of innovating with new and unique products and services, using innovative personalized marketing and adjusting the mix of merchandise to match customers' needs and preferences. A key component of the front store strategy is the ExtraCare® card program, which is one of the largest and most successful retail loyalty programs in the U.S. The ExtraCare program allows the Company to balance marketing efforts so it can reward its best customers by providing them with automatic sale prices, customized coupons, ExtraBucks® rewards and other benefits. The Company also offers a subscription-based membership program, ExtraCare Plus™, under which members are entitled to a suite of benefits delivered over the course of the subscription period, as well as a promotional reward that can be redeemed for future goods and services. The Company continues to launch and enhance new and exclusive brands to create unmatched offerings and deliver other unique product offerings, including a full range of high-quality proprietary brand products that are only available through CVS stores. The Company currently carries approximately 4,500 proprietary brand products, which accounted for approximately 20% of front store revenues during 2025.

Specialty and Mail Order Pharmacy Fulfillment Services
The Pharmacy & Consumer Wellness segment provides pharmacy fulfillment services to support the Health Services segment's specialty and mail order pharmacy offerings, in exchange for which the Health Services segment pays an administrative service fee to the Pharmacy & Consumer Wellness segment.

Long-term Care Pharmacy Operations
The Pharmacy & Consumer Wellness segment distributed prescription drugs and provided related pharmacy consulting and ancillary services to long-term care facilities and other care settings through Omnicare and certain of its subsidiary entities prior to the deconsolidation of these subsidiaries in September 2025. See "Subsidiary Bankruptcy" within Note 1 ''Significant Accounting Policies'' included in Item 8 of this 10-K for additional information.

Community Location Development

CVS Health's community health destinations are an integral part of its ability to meet the needs of consumers and maintain its leadership position in the changing health care landscape. When paired with its rapidly expanding digital presence, the Company's physical presence in thousands of communities across the country represents a competitive advantage by allowing it to develop deep and trusted relationships through everyday engagement in consumer health. The Company's community health destinations have played, and will continue to play, a key role in the Company's continued growth and success. During 2025, the Company opened 87 new locations, relocated 5 locations and closed 243 locations.

The Company's continuous assessment of its national footprint is an essential component of competing effectively in the current health care environment. On an ongoing basis, the Company evaluates changes in population, consumer buying patterns and future health needs to assess the ability of its existing stores and locations to meet the needs of its consumers and the business. During the third quarter of 2024, in connection with an enterprise-wide restructuring plan, the Company completed a strategic review of its retail business and announced plans to close certain retail stores in 2025. During the year ended December 31, 2025, the Company closed 221 retail stores in connection with this action.

Pharmacy & Consumer Wellness Information Systems

The Company has continued to invest in information systems to enable it to deliver exceptional customer service, enhance safety and quality, and expand patient care services while lowering operating costs. The proprietary WeCARE Workflow tool supports pharmacy teams by prioritizing work to meet customer expectations, facilitating prescriber outreach, and seamlessly integrating clinical programs. This solution delivers improved efficiency and enhances customer experience, as well as provides a framework to accommodate the evolution of pharmacy practice and the expansion of clinical programs. The Company's Health Engagement Engine technology and data science clinical algorithms enable the Company to help identify opportunities for pharmacists to deliver face-to-face counseling regarding patient health and safety matters, including medication adherence issues, gaps in care and management of certain chronic health conditions. The Company's digital strategy is to empower the consumer to navigate their pharmacy experience and manage their condition through integrated online and mobile solutions that offer utility and convenience. The Company has also established tools which enable customers to schedule vaccination appointments through CVS.com, provide instructions and notifications to the customer regarding the services, and, following administration, allow customers to access digital results for tests and records for vaccinations.

Pharmacy & Consumer Wellness Customers

The success of the Pharmacy & Consumer Wellness segment's businesses is dependent upon the Company's ability to establish and maintain contractual relationships with pharmacy benefit managers and other payors on acceptable terms. Substantially all of the Pharmacy & Consumer Wellness segment's pharmacy revenues are derived from pharmacy benefit managers, managed care organizations ("MCOs"), government funded health care programs, commercial employers and other third-party payors. No single Pharmacy & Consumer Wellness payor accounted for 10% or more of the Company's consolidated total revenues in 2025, 2024 or 2023.

Pharmacy & Consumer Wellness Seasonality

The Pharmacy & Consumer Wellness segment's quarterly operating income progression may be impacted by (i) the timing and severity of the cough, cold and flu season, most notably during first and fourth quarters, resulting in higher administration of vaccines during those periods, (ii) the December holiday season which generally results in higher volume in the front store, and (iii) uncharacteristic or extreme weather conditions, which may adversely affect consumer shopping patterns.

Pharmacy & Consumer Wellness Competition

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

Corporate/Other Segment

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

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

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.

Use of AI

The Company recognizes that AI has the potential to reimagine health care, including simplifying care navigation, reducing costs, transforming consumer experience and enhancing the quality of and access to care. The Company uses AI as an augmentative technology to minimize provider/payer friction, enable advanced consumer self-service through AI-assistants while enhancing human touch when desired, offer simplified health and care navigation, expand access, streamline and optimize internal operations and modernize operating platforms. As AI technology advances, CVS Health is committed to doing its part to help ensure the safe, responsible, ethical and consumer-centric use of AI.

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, as well as long-term borrowings. For additional information on the Company's working capital practices, see "Liquidity and Capital Resources" in the MD&A included in Item 7 of this 10-K. Employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans (with the exception of Medicare Part D services, which are described below), labor groups and expatriates, which represent the vast majority of Health Care Benefits segment revenues, are typically reconciled on a monthly basis, but inconsistent timing of

payments may cause volatility from time to time. As a provider of Medicare Part D services, the Company contracts annually with CMS. Utilization of services each plan year results in the accumulation of either a receivable from or a payable to CMS. The timing of settlement of the receivable or payable with CMS takes several quarters, which impacts working capital from year to year. The majority of the Pharmacy & Consumer Wellness segment non-pharmacy revenues are paid in cash, or with debit or credit cards. Managed care organizations, pharmacy benefit managers, government funded health care programs, commercial employers and other third-party insurance programs, which represent the vast majority of the Company's consolidated pharmacy revenues, typically settle in less than 30 days. The remainder of the Company's consolidated pharmacy revenues are paid in cash, or with debit or credit cards.

Human Capital

Overview

At CVS Health, we share a single, clear purpose: to simplify health care one person, one family and one community at a time. We devote significant time and attention to attract, develop and retain talent who deliver high levels of service to our customers. Our commitment includes a competitive rewards package and programs that support our diverse range of colleagues in rewarding and fulfilling careers. As of December 31, 2025, we employed over 300,000 colleagues primarily in the U.S. including in all 50 states, the District of Columbia and Puerto Rico, approximately 73% of whom were full-time.

We believe engaged colleagues produce stronger business results and are more likely to build a career with the Company. Each year we conduct engagement surveys that provide colleagues the opportunity to share opinions and experiences with respect to their role, their team, and the enterprise to help CVS Health Corporation's Board of Directors (the "Board") and our management identify where we can improve colleague experience. These surveys cover a broad range of topics including development and opportunities, recognition, performance, belonging, well-being, compliance, and continuous improvement. In 2025, we conducted engagement surveys in both April and September. More than 200,000 colleagues participated in each survey and overall engagement improved across surveys.

The Board, our Chief Executive Officer ("CEO") and our Chief People Officer provide oversight of our human capital strategy, which consists of the following categories: workforce strategy; total rewards; and health, safety and environment.

Workforce Strategy

At CVS Health, our goal is to attract the most talented and qualified workforce in health care and to develop and retain a work force to support and advance our strategic priorities. We believe that our workforce strategy should be responsive to and reflect the broad and diverse communities whose health care needs we serve.

We are committed to developing a pipeline of critical skills to power CVS Health for the future. We partner with colleges and universities across many professional fields. For example, the CVS Health PharmD tuition assistance program is available to all eligible CVS Pharmacy interns. In addition, CVS Health is creating transformational solutions to workforce development through dynamic community Workforce Innovation and Talent Centers (WITCs), tailored to the specific needs of each community, incorporating education and skill development, as we help advance future leaders.

Training and development provide colleagues the support they need to perform well in their current roles while planning and preparing for future roles and career growth. Our broad training practices include updated, tech-enabled tools and keep our colleagues informed of new developments in our industry that are relevant to their roles. During the year ended December 31, 2025, our colleagues invested approximately 16 million hours in learning and development courses.

Our ambition is to be America's most trusted health care company. Achieving that starts with building and sustaining a culture of trust within our organization. That is why trust and respect are cornerstones of our culture, the foundation of our workplace strategy. To simplify health care and deliver our best when people need us the most, we strive every day to achieve the highest level of trust and respect from our colleagues, our customers, and the communities we serve. Our values guide how we lead and collaborate. We emphasize care, innovation, accountability, safety and quality. Those aspects of our culture show up in our Respect Works Here campaign.

Our practices have earned national recognition, including designations as a military-friendly, veteran-friendly, and disability-inclusive employer.

We disclose more information on our workforce strategy in our annual Impact Report.

Total Rewards

We strive to offer a comprehensive and competitive mix of pay and benefits to meet the varying needs of our colleagues and their families. In addition to competitive wages, the comprehensive list of programs and benefits we offer include annual bonuses, stock awards, 401(k) plans including matching company contributions, no cost comprehensive wellness screenings, tobacco cessation and weight management programs, no cost confidential counseling and no cost financial navigation support, an employee stock purchase plan, health care and insurance benefits, paid time off, flexible work schedules, family leave, dependent care resources, colleague assistance programs and tuition assistance, retiree medical access, and discount programs, among many others, depending on eligibility.

Health, Safety and Environment

We have a strong commitment to providing a safe working environment. We have implemented an environmental health and safety management system to support adherence and monitoring of programs designed to make our various business operations compliant with applicable occupational safety and health regulations and requirements. Our Health, Safety, and Environment Department oversees the implementation and adherence to programs like powered industrial truck training, materials handling and storage, selection of personal protective equipment and fall protection systems.

We utilize a Management Information System to track compliance, analyze data and concentrate on key areas of risk to reduce the chance of workplace incidents. We focus on identifying causes and improving performance when workplace incidents occur. We capture colleague observations and feedback through programs like our Behavior Based Safety and our Safety Hazard and Awareness Reporting Program. We also engage leaders in promoting a culture of safety and measure performance through a comprehensive safety index that leverages both leading and lagging indicators. With safety task forces in place at each distribution center, we empower leaders and safety business partners to identify policies, procedures and processes that could improve their own operations.

Impact Strategy

Overview

Our Healthy 2030 impact strategy outlines how we are creating a healthier, more sustainable future for all as we work to fulfill our ambition to simplify health care one person, one family, and one community at a time. Through four pillars – Healthy People, Healthy Business, Healthy Community and Healthy Planet – we focus on measurable actions that improve health outcomes, strengthen communities and protect the environment. Rooted in our purpose-driven culture, our impact strategy positions us to lead with integrity and innovation to deliver meaningful change while sustaining long-term business performance.

Healthy People

We put health at the center of everything we do. By elevating the experience of our customers, we are elevating the very essence of health care. We connect people to the care they need, advance affordability, simplify access, and ultimately help people live healthier lives. Our investments in health services and programs drive outcomes, reduce barriers to care and deliver innovative solutions that set new standards for accessible, high-quality care.

Healthy Business

Our greatest strength is our people. With a talented and diverse workforce of more than 300,000 colleagues, we uphold the highest standards of ethics and transparency while creating value and delivering on our promises. Through education, leadership development and workforce training, we empower colleagues and strengthen talent pipelines. At the same time, we embed strong governance and responsible practices across our supply chain to ensure integrity, sustainability and accountability across our operations.

Healthy Community

We work alongside communities to improve health outcomes and unlock opportunities for workforce readiness. From supporting heart health, mental health and healthy aging to addressing climate-related health impacts, we take a holistic approach to create a healthier future. Our programs tackle food insecurity, improve access to workforce training and provide

educational opportunities nationwide. In times of crisis, we respond swiftly to meet evolving needs locally. Our colleagues amplify impact through volunteerism and collaboration in communities where we live and work.

Healthy Planet

We advance initiatives to protect the health of people and the planet. We are strengthening our business to withstand extreme weather events, ensuring continuity of care and access for patients when it matters most. Our efforts include strengthening environmental health and resilience, reducing greenhouse gas emissions, sourcing renewable energy and driving packaging innovation to minimize waste and unnecessary plastics. We lead with purpose to build a healthier world for generations to come.

Intellectual Property

The Company has registered and/or applied to register a variety of trademarks and service marks used throughout its businesses, as well as domain names, and relies on a combination of copyright, patent, trademark and trade secret laws, in addition to contractual restrictions, to establish and protect the Company's proprietary rights. The Company regards its intellectual property as having significant value in the Health Care Benefits, Health Services and Pharmacy & Consumer Wellness 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 Pharmacy & Consumer Wellness segment, including insurers, Medicare plans, Managed Medicaid plans and MCOs, are themselves subject to extensive regulations that affect the design and implementation of prescription drug benefit plans that they sponsor.

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

The Company has internal control policies and procedures and conducts training and compliance programs for its employees to help prevent, detect and correct prohibited practices. However, if the Company's employees or agents fail to comply with applicable laws governing its operations, it may face investigations, prosecutions and other legal proceedings and actions that could result in civil penalties, administrative remedies and criminal sanctions, and any such action could result in reputational harm. Any failure or alleged failure to comply with applicable laws and regulations summarized below, or any adverse applications or interpretations of, or changes in, the laws and regulations affecting the Company and/or its businesses, could have a material adverse effect on the Company's operating results, financial condition, cash flows and/or stock price. See Item 1A of this 10-K, "Risk Factors—Risks from Changes in Public Policy and Other Legal and Regulatory Risks," and Item 3 of this 10-K, "Legal Proceedings," for further information.

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

laws or regulations, including the laws and regulations described in this Government Regulation section, as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; or (v) adverse developments in pending or future legal proceedings against or affecting the Company, including *qui tam* lawsuits, or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

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

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

The AKS prohibits, among other things, knowingly and willfully offering, paying, soliciting or receiving remuneration, directly or indirectly, in cash or kind, to induce or reward either the referral of an individual for, or the purchase, order or recommendation of, any good or service, for which payment may be made in whole or in part under federal health care programs, such as Medicare and Medicaid. Some court decisions have held that the statute may be violated even if only one purpose of remuneration is to induce referrals. Certain of the Company's programs involve arrangements with payments intended to influence behavior relative to Medicare and other federal health care program beneficiaries, including risk sharing and "gainsharing" arrangements. While there is no fixed definition of a gainsharing arrangement, the term typically refers to an arrangement in which a share of cost savings for patient care attributable in part to a physician's efforts are shared with the physician. The Office of the Inspector General of HHS (the "OIG") has recognized that there are legitimate interests in enlisting physicians in effort to reduce unnecessary costs from the health care system and, if appropriately structured, such gainsharing arrangements should not violate the AKS. Effective in early 2021, CMS and the OIG established new safe harbors that protect certain value-based arrangements, and the Company has integrated its understanding of these safe harbors into its new and existing programs.

The Stark Law prohibits a physician who has a financial relationship, or who has an immediate family member who has a financial relationship, with entities providing "designated health services" ("DHS") from referring Medicare patients to such entities for the furnishing of DHS, unless an exception applies. The Stark Law prohibits any entity providing DHS that has received a prohibited referral from presenting, or causing to be presented, a claim or billing for the services arising out of the prohibited referral. Similarly, the Stark Law prohibits an entity from "furnishing" DHS to another entity with which it has a financial relationship when that entity bills for the service. The prohibition applies regardless of the reasons for the financial relationship and the referral. Unlike the AKS, the Stark Law is a strict liability statute where unlawful intent need not be demonstrated. Although uncertainty exists, some federal agencies and some courts have taken the position that the Stark Law also applies to Medicaid. With respect to certain CMS innovation models in which we may participate, the OIG and CMS jointly issued waivers of the Stark Law. In early 2021, CMS established new exceptions to the Stark Law that protect certain value-based arrangements, and the Company has integrated exceptions into its processes and procedures. Various states have enacted similar laws.

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 and the Stark Law or similar state laws.

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

turn could adversely affect the Company's ability to continue to participate in certain product lines and/or geographies that it serves today.

Although the U.S. Supreme Court dismissed a challenge to the constitutionality of the ACA and issued an opinion preserving the ACA and its consumer protections, there may be continued efforts to invalidate, modify, repeal or replace portions of it. In addition to litigation, parts of the ACA continue to evolve through the promulgation of executive orders, legislation, regulations and guidance at the federal or state level. The Company expects the ACA, including potential changes thereto, to continue to significantly impact its business operations and operating results, including pricing, medical benefit ratios ("MBRs") and the geographies in which the Company's products are available.

Medicare Regulation - The Company's Medicare Advantage, Medicare stand-alone Part D PDP and other Medicare products are highly 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. Medicare regulations also have the potential to impact products and services used by Medicare beneficiaries, including services provided by Oak Street Health and Signify Health.

The provisions of the ACA significantly increased the Company's exposure to funding and regulation of, and changes in government policy with respect to and/or funding or regulation of, the various Medicare programs in which the Company participates, including changes in the amounts payable to us under those programs and/or new reforms or surcharges on existing programs. For example, the ACA requires minimum MLRs for Medicare Advantage and Medicare Part D plans of 85%. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS. It is possible that certain Medicare Advantage contracts may not meet the 85% MLR for consecutive years.

Payments the Company receives from CMS for its Medicare Advantage and Part D businesses also are subject to risk adjustment based on the health status of the individuals enrolled. Elements of that risk adjustment mechanism continue to be challenged by the U.S. Department of Justice (the "DOJ"), the OIG and CMS itself. For example, CMS made significant changes to the structure of the hierarchical condition category model in version 28, which may impact risk adjustment factor ("RAF") scores for a larger percentage of Medicare Advantage beneficiaries and could result in changes to beneficiary RAF scores with or without a change in the patient's health status. CMS continuously evaluates how and where risk adjustment is captured, which from time-to-time has included the capture of diagnosis codes from in home visits and chart reviews. A legislative or regulatory change to the ability of Medicare Advantage plans to use home visits as a means to evaluate and diagnose their members' health conditions, or substantial changes in the risk adjustment mechanism, including changes that result from enforcement or audit actions, could: materially affect the amount of the Company's Medicare reimbursement; require the Company to raise prices or reduce the benefits offered to Medicare beneficiaries; impact the services provided by, or the financial performance of, Oak Street Health and Signify Health; and potentially limit the Company's (and the industry's) participation in the Medicare program.

The Company offers a wide range of Medicare products across the country to meet the diverse health care needs of its customers, including Individual Medicare Advantage, Group Medicare, Special Needs Plans, Medicare Supplement plans and Prescription Drug Plans.

Additionally, there is growing interest among policymakers in re-evaluating how benchmarks are constructed in Medicare Advantage compared to Medicare Fee-For-Service programs. Policymakers could pursue various strategies including, among other things, re-evaluating benchmark construction, risk adjustment methodology and alignment in quality measures. In addition, the CMS Innovation Center could offer new models or suspend present models that could have a material impact on the success of the Company's Oak Street Health business. For example, the CMS Innovation Center could mandate or offer participation in certain models that require providers and/or risk-bearing entities to take risk for a geographic population of patients, or it could look to methodologies that infer risk, survey data and non-diagnosis-based data with potential impacts to the Company's businesses. Uncertainties about how policymakers and CMS may re-evaluate how benchmarks are constructed in Medicare Advantage, including the future of VBC and mandatory participation, could create new considerations for the Company.

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 dual eligible plans, exclude us from participating in one or more Medicare, dual eligible or dual eligible special needs plan programs

and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS regulations or its Medicare contractual requirements. The Company's Medicare Supplement products are regulated at the state level and are subject to similar significant compliance requirements and risks.

Going forward, the Company expects CMS, the OIG, the DOJ, other federal agencies and the U.S. Congress to continue to scrutinize closely each component of the Medicare program (including Medicare Advantage, PDPs, dual eligible plans, broker compensation and marketing, prior authorization, and provider network access and adequacy), modify the terms and requirements of the program and possibly seek to recast or limit private insurers' roles. Any of the federal agencies noted above or U.S. Congress may also recommend changes or take additional action with respect to the way in which brokers and agents are compensated for selling our Medicare Advantage and Part D plans.

In addition, the Inflation Reduction Act, enacted in August 2022 contains changes to the Part D program that have and will shift more of the claim liability to plans and away from the government, including a complete redesign of the Part D standard benefit effective in 2025, which may reduce the Company's flexibility to design competitive offerings. Given the significant changes and resulting increase in Part D premiums from plans, CMS instituted a voluntary demonstration in 2025 to test whether additional premium stabilization and revised risk corridors for stand-alone PDPs increase the efficiency and economy of services for Medicare Part D members. The Company has opted to participate in the demonstration in 2025 and 2026, and CMS may choose to continue the demonstration for 2027.

In addition, the prices for the first ten drugs in the Medicare Drug Negotiation Program (the "Negotiation Program") take effect in 2026, and the program will grow over time as additional drugs are negotiated by the government each year, with up to 100 total Part B and D drugs selected for the Negotiation Program by 2031. The Negotiation Program mandates direct negotiation by the government of prices for certain drugs in Medicare and negotiated drugs must be covered on all plan formularies.

It is also possible that Congress may consider changes to Medicare Advantage payment policies due to recent recommendations by the Medicare Payment Advisory Commission and to reduce the potential added cost burden of costly new benefits, or policies that impact drug pricing such as price controls and drug price inflationary rebates applied to pharmaceutical manufacturers. In addition, states are increasingly requiring companies to offer Medicaid within a state and conducting competitive bid processes to qualify to offer dual eligible products.

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

Medicaid Regulation - The Company is exposed to changes in government policy with respect to and/or regulation of the various Medicaid and dual eligible plan programs in which the Company participates, including changes in the amounts payable to the Company under those programs.

In addition to a quality rating system that applies to Medicaid and Managed Medicaid plans, federal regulations give states the option to choose to establish a minimum MLR of at least 85% for their Managed Medicaid plans, including those offered by the Company. Regardless of whether a state establishes a minimum MLR, it must use plan-reported MLR data to set future payment rates for managed care, so that its plans will "reasonably achieve" an MLR of at least 85%. For Managed Medicaid products, states may use more stringent definitions of "medical loss ratio" or impose other requirements related to minimum MLR. Minimum MLR requirements and similar actions further limit the level of margin the Company can earn in its Insured Medicaid products while leaving the Company exposed to medical costs that are higher than those reflected in its pricing. The Company also may be subject to significant fines, penalties, premium refunds and litigation if it fails to comply with minimum MLR laws and regulations.

States may also establish their own standards and use discretion in choosing what determines compliance within Medicaid contracts, including, among other provisions, standards for determining provider network adequacy, staffing, service operations, utilization management, beneficiary care management, provider support, data maintenance and reporting and claims payment. States have flexibility related to rate setting and provider network adequacy that could adversely or positively impact the Company's Medicaid plans.

The "One Big Beautiful Bill Act" also known as the "Working Families Tax Cut Act" of 2025 makes changes to Medicaid eligibility rules and financing, which will lead to reduced eligibility for Medicaid beneficiaries and reduced state funding, which will in turn impact Medicaid benefits and payment rates. Given these changes, states that have not done so are unlikely to consider Medicaid expansion. States may opt out of the elements of the ACA requiring expansion of Medicaid coverage without losing their current federal Medicaid funding.

The economic aspects of the Medicaid and dual eligible 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 (and redeterminations of eligibility), provider network adequacy requirements (including requiring the inclusion of specified high cost providers in the Company's networks) and program structure. In some states, current Medicaid and dual eligible funding and premium revenue may not be adequate for the Company to continue program participation. The Company's Medicaid and dual eligible contracts with states (or sponsors of Medicaid managed care plans) are subject to cancellation by the state (or the sponsors of the managed care plans) after a short notice period without cause (e.g., when a state discontinues a managed care program) or in the event of insufficient state funding.

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

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

Medicare and Medicaid Audits - CMS regularly audits the Company's performance to determine its compliance with CMS' regulations and its contracts with CMS and to assess the quality of services it provides to Medicare Advantage and PDP beneficiaries. For example, CMS conducts risk adjustment data validation ("RADV") audits of a subset of Medicare Advantage contracts for each contract year. Since 2011, CMS has selected certain of the Company's Medicare Advantage contracts for various years for RADV audit, and the number of RADV audits continues to increase. The OIG also is auditing the Company's risk adjustment data and that of other companies, and the Company expects CMS and the OIG to continue auditing risk adjustment data. The Company also has received Civil Investigative Demands ("CIDs") from, and provided documents and information to, the Civil Division of the DOJ in connection with investigations of the Company's identification and/or submission of diagnosis codes related to risk adjustment payments, including patient chart review processes, under Parts C and D of the Medicare program. In May 2025, CMS announced it would audit every Medicare Advantage contract each payment year, with an expedited plan to complete audits for payment years 2018 through 2024 by early 2026. In September 2025, the U.S. District Court, Northern District of Texas vacated CMS' 2023 RADV Audit Final Rule which eliminated the application of a fee-for-service adjuster in contract-level RADV audits but continued the use of extrapolation in audits of Medicare Advantage Organizations. CMS has appealed this ruling.

In addition, state Medicaid agencies regularly audit, and state officials regularly investigate, the Company's performance across all areas of its contractual obligations to the state to determine compliance and quality of services. The Company may be subject to, among other penalties, significant fines, sanctions, corrective actions, and enrollment freezes depending on the findings of these audits and reviews. The Company's ongoing performance and compliance with program requirements can impact our ability to expand and retain Medicaid business. State Medicaid agencies are also increasingly using the audit process

to challenge the legality of PBM practices, such as guaranteed effective rate reconciliations with retail pharmacies and transmission fees.

Medicare Star Ratings - A portion of each Medicare Advantage plan's reimbursement is tied to the plan's "star ratings." The star rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management, compliance and overall customer satisfaction. Only Medicare Advantage plans with an overall star rating of 4 or more stars (out of 5 stars) are eligible for a quality bonus in their basic premium rates. The Company's 2026 star ratings were used to determine which of its Medicare Advantage plans have ratings of 4 stars or higher and qualify for bonus payments in 2027. Based on the Company's membership as of December 2025, more than 81% of the Company's Medicare Advantage members are in 2026 Medicare Advantage plans that are rated 4 stars or higher and more than 63% of the Company's Medicare Advantage members are in a 4.5-star plan for 2026. CMS also gives PDPs star ratings that affect each PDP's enrollment. Medicare Advantage and PDP plans that are rated less than 3 stars for three consecutive years are subject to contract termination by CMS. CMS continues to revise its star ratings system to make it harder to achieve 4 or more stars. There can be no assurances that the Company will be successful in maintaining or improving its star ratings in future years. Accordingly, the Company's Medicare Advantage plans may not continue to be or become eligible for full level quality bonuses, which could adversely affect the benefits such plans can offer, reduce membership and/or reduce profit margins.

Medicare Payment Rates - In April 2025, CMS issued its final notice detailing final 2026 Medicare Advantage payment rates. Based on CMS' notice, Medicare Advantage rates resulted in an expected average increase in revenue for the Medicare Advantage industry of 7.16%, which includes a risk score trend increase of 2.10%. Risk scores vary among Medicare Advantage plans depending on the specific population served, so this increase does not represent an actual guaranteed payment increase. Without including the risk score trend increase, the 2026 rates result in an expected average increase in revenue for the Medicare Advantage industry of 5.06%, though the rates may vary widely depending on the provider group and patient demographics. On January 26, 2026, CMS issued an advance notice detailing proposed 2027 Medicare Advantage payment rates. The 2027 Medicare Advantage rates, if finalized as proposed, will result in an expected average increase in revenue for the Medicare Advantage industry of 2.54%, which includes a risk score trend increase of 2.45%. Without including the risk score trend increase, the advance 2027 rates will result in an expected average increase in revenue for the Medicare Advantage industry of 0.09%, though the rates may vary widely depending on the provider group and patient demographics. CMS intends to publish the final 2027 rate announcement no later than April 6, 2026.

The Company faces a challenge from the impact of the increasing cost of medical care (including prescription medications), changes to methodologies for determining payments and CMS local and national coverage decisions that require the Company to pay for services and supplies that are not factored into the Company's bids. The federal government may seek to impose restrictions on the configuration of pharmacy or other provider networks for Medicare Advantage and/or PDP plans, or otherwise restrict the ability of these plans to alter benefits, negotiate prices or establish other terms to improve affordability or maintain viability of products. The Company currently believes that the payments it has received and will receive in the near term are adequate to justify the Company's continued participation in the Medicare Advantage and PDP programs, although there are economic and political pressures to continue to reduce spending on the program, and this outlook could change.

340B Drug Pricing Program – The 340B Drug Pricing Program, which is overseen by the HHS and the Health Resources and Services Administration ("HRSA"), allows eligible Covered Entities to purchase prescription drugs from manufacturers at a steep discount. A reduction in Covered Entities' participation in contract pharmacy arrangements, a reduction in the use of the Company's administrative services by Covered Entities or a reduction in drug manufacturers' participation in the program could result from enforcement actions, rule changes or otherwise and could materially and adversely affect the Company.

In December 2025, the U.S. District Court of Maine issued a preliminary injunction halting the implementation of the 340B Rebate Model Pilot Program (the "Pilot"). The court held that the Pilot is likely arbitrary and capricious under the Administrative Procedure Act because the Pilot's potential impact on 340B hospitals was not adequately considered; the decision has been appealed to the First Circuit Court of Appeals. Under approved plans under the Pilot, pharmaceutical manufacturers were to implement 340B-discounted prices for pertinent drugs tied to the Inflation Reduction Act negotiation program through retrospective rebates rather than upfront discounts that traditionally have been extended on 340B drug purchases. Drugs were to be subject to the Pilot for at least one year, starting January 1, 2026. The Office of Pharmacy Affairs ("OPA") had stated that it would consider extending the program to additional drugs. Under the Pilot, OPA would evaluate the effectiveness of the rebate model plans through data reporting from participating manufacturers and feedback from Covered Entities. At this time, it is uncertain whether the Pilot will resume, and if it does resume it is uncertain what impacts the Pilot may have on the Company's financial performance. It is also uncertain whether other changes to the 340B program may be effected through legislation, regulation, or judicial decision and, if so, what impacts such changes may have on the Company's financial performance.

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

Antitrust and Unfair Competition - The U.S. Federal Trade Commission ("FTC") investigates and prosecutes practices that are "unfair trade practices" or "unfair methods of competition." Numerous lawsuits have been filed throughout the U.S 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 Health Care Benefits or Health Services segment product offering, the Company's business arrangements and uses of confidential information may be subject to heightened scrutiny from an anti-competitive perspective and possible challenge by state and/or federal regulators and/or private parties.

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

The federal Health Insurance Portability and Accountability Act of 1996, as it has been amended from time to time, and the regulations issued thereunder (collectively, "HIPAA"), impose extensive requirements on the way in which health plans, providers, health care clearinghouses and their business associates use, disclose and safeguard protected health information ("PHI"). Criminal penalties and civil sanctions may be imposed for failing to comply with HIPAA's privacy and security standards.

In addition to HIPAA, state 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, reproductive health records 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.

There is also a continuing trend of states enacting more comprehensive privacy laws and regulations addressing consumer rights to data access, deletion, protection or transparency, such as the California Consumer Privacy Act ("CCPA"). States also are starting to issue regulations and proposed regulations specifically related to cybersecurity, such as the regulations issued by the New York Department of Financial Services, as well as regulating use of artificial intelligence technologies. Complying with conflicting cybersecurity regulations, which may differ from state to state, requires significant resources. In addition, differing approaches to state privacy, cybersecurity and/or artificial intelligence regulation and varying enforcement philosophies may significantly restrict the Company's ability to standardize its products and services across state lines. Widely-reported large scale cyberattacks in the U.S. and abroad increase the likelihood that additional data security legislation will be

considered by additional states or by the federal government. 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.

See Item 1C of this 10-K, "Cybersecurity," for more information on the Company's cybersecurity risk management and governance.

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

Transparency Laws - The Transparency in Coverage Rule requires health insurers to disclose negotiated prices of drugs, medical services, supplies and other covered items. The rule also requires group health plans and health insurance issuers in the individual and group markets to disclose cost-sharing information upon request, to a participant, beneficiary, or enrollee and require plans and issuers to publicly disclose in-network provider rates, historical out-of-network allowed amounts and the associated billed charges, and negotiated rates and historical net prices for prescription drugs. Insurers are required to implement a consumer tool and disclose data in a machine readable file.

Additional transparency regulations require group health plans and health insurance issuers to report, on an annual basis, certain prescription drug costs, overall spending on health services and prescription drugs, and information about premiums and the impact of rebates and other remuneration on premiums and out-of-pocket costs.

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

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

Telehealth Laws - States generally require providers providing professional health care services, whether in person or via telehealth, to a patient residing within the state to be licensed in that state. States have established a variety of licensing and other regulatory requirements around the provision of telehealth services. These requirements vary from state to state. Many states require notification of certain material events be provided to the applicable licensing agency. In addition, there are federal telehealth requirements applicable to Medicare and state program specific requirements applicable to Medicaid. The Company has established systems for ensuring that its providers are appropriately licensed under applicable state law and that their

provision of telehealth service to patients with whom we interact occurs in compliance with applicable laws and regulations. Failure to comply with these laws and regulations could result in licensure actions against the providers as well as civil, criminal or administrative penalties against the providers and/or entities engaging the services of the providers.

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

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

The states of domicile of the Company's regulated subsidiaries have statutory risk-based capital ("RBC") requirements for health and other insurance companies and HMOs based on the National Association of Insurance Commissioners' (the "NAIC") Risk-Based Capital for Insurers Model Act (the "RBC Model Act"). These RBC requirements are intended to assess the capital adequacy of life and health insurers and HMOs, taking into account the risk characteristics of a company's investments and products. The RBC Model Act sets forth the formula for calculating RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual company's business. In general, under these laws, an insurance company or HMO must submit a report of its RBC level to the insurance department or insurance commissioner of its state of domicile for each calendar year. At December 31, 2025, all of the Company's insurance and HMO subsidiaries were above the RBC 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 14 ''Shareholders' Equity'' included in Item 8 of this 10-K.

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

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

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

Environmental and Safety Regulation - The Company's businesses are subject to various federal, state and local laws, regulations and other requirements pertaining to protection of the environment, public health and employee safety, including,

for example, regulations governing the management of hazardous substances, the cleaning up of contaminated sites, and the maintenance of safe working conditions in the Company's retail locations, distribution centers and other facilities. Governmental agencies at the federal, state and local levels continue to focus on the retail and health care sectors' compliance with such laws and regulations, and have at times pursued enforcement activities. Any failure to comply with these regulations could result in fines or other sanctions by government authorities.

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

Some of the Company's health and related benefits and large case pensions products and services and related fees also are subject to potential issues raised by judicial interpretations relating to ERISA. Under those interpretations, together with DOL regulations, the Company may have ERISA fiduciary duties with respect to medical members, 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.

Preemption - ERISA generally preempts most state and local laws that relate to employee benefit plans, but the extent of the preemption continues to be reviewed by courts, including the U.S. Supreme Court. For example, federal courts affirmed that the Oklahoma Insurance Department could not enforce a state law against PBMs that contained provisions that alter and limit some of the options that an ERISA plan can use and decided that the Oklahoma law was preempted by ERISA and, in part, by Medicare Part D. Significant ERISA preemption litigation is ongoing in several other federal jurisdictions addressing a wide range of state laws regulating PBMs including laws imposing significant restrictions on the relationships between PBMs and the employee benefit plans they administer.

Other Legislative Initiatives and Regulatory Initiatives - The U.S. federal and state governments, as well as governments in other countries where the Company does business, continue to enact and seriously consider many broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system and the Company's businesses, operating results and/or cash flows. For example, significant legislative and/or regulatory measures which are or recently have been under consideration include prohibiting pharmacies affiliated with a PBM from acquiring a pharmacy license in a state and other restrictions on affiliated entities. It is uncertain whether the Company can counter the potential adverse effects of such potential legislation or regulation on its operating results or cash flows, including whether it can recoup, through higher premium rates, expanded membership or other measures, the increased costs of mandated coverage or benefits, assessments, fees, taxes or other increased costs, including the cost of modifying its systems to implement any enacted legislation or regulations.

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

Federal Employee Health Benefits Program - The Company's subsidiaries contract with the Office of Personnel Management (the "OPM") to provide managed health care services under the FEHB program in their service areas. These contracts with the OPM and applicable government regulations establish premium rating arrangements for this program. In addition to other requirements, such as the Transparency in Coverage Rule note above, OPM regulations require that community-rated FEHB plans meet a FEHB program-specific minimum MLR by plan code and market. Managing to these rules is complicated by the simultaneous application of the minimum MLR standards and associated premium rebate requirements of the ACA. The Company also has a contractual arrangement with carriers for the FEHB program, such as the

BlueCross BlueShield Association, to provide pharmacy services to federal employees, postal workers, annuitants, and their dependents under the Government-wide Service Benefit Plan, as authorized by the FEHB Act and as part of the FEHB program. Additionally, the Company manages certain FEHB plans on a "cost-plus" basis. These arrangements subject the Company to certain aspects of the FEHB Act, and other federal regulations, such as the FEHB Acquisition Regulation, that otherwise would not be applicable to the Company. The OPM also is auditing the Company and its other contractors to, among other things, verify that plans meet their applicable FEHB program-specific MLR and the premiums established under the OPM's Insured contracts and costs allocated pursuant to the OPM's cost-based contracts are in compliance with the requirements of the applicable FEHB program. The OPM may seek premium refunds or institute other sanctions against the Company if it fails to comply with the FEHB program requirements.

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

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

International Regulation - The Company'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 European Union's ("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 presence of operations in foreign countries potentially increases the Company's exposure to the anti-bribery, anti-corruption and anti-money laundering provisions of U.S. law, including the Foreign Corrupt Practices Act of 1977 (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 U.S., health care professionals are employed by the government. Therefore, the Company's dealings with them are subject to regulation under the FCPA. Violations of the FCPA and other anti-corruption laws may result in severe criminal and civil sanctions as well as other penalties, and there continues to be a heightened level of FCPA enforcement activity by the SEC and the DOJ.

Anti-Money Laundering Regulations - Certain lines of the Company's businesses are subject to anti-money laundering regulations. Those lines of business have implemented anti-money laundering policies designed to ensure their compliance with the regulations.

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

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

Laws and Regulations Related to the Health Care Benefits Segment

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

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

- Grant, suspend and revoke the Company's licenses to transact business;
- Suspend or exclude the Company from participation in government programs;
- Suspend or limit the Company's authority to market products;
- Regulate many aspects of the products and services the Company offers, including the pricing and underwriting of many of its products and services;
- Assess damages, fines and/or penalties;
- Terminate the Company's contract with the government agency and/or withhold payments from the government agency to the Company;
- Impose retroactive adjustments to premiums and require the Company to pay refunds to the government, customers and/or members;
- Restrict the Company's ability to conduct acquisitions or dispositions;
- Require the Company to maintain minimum capital levels in its subsidiaries and monitor its solvency and reserve adequacy; and/or
- Regulate the Company's investment activities on the basis of quality, diversification and other quantitative criteria.

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

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

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

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

reflected in its pricing. The Company also may be subject to significant fines, penalties, premium refunds and litigation if it fails to comply with minimum MLR laws and regulations.

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

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

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

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

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

Laws and Regulations Related to the Health 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 Health Services segment specifically. Among these are the following:

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

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

The Company's PBM service contracts, including those in which the Company assumes certain risks under performance guarantees or similar arrangements, are generally not subject to insurance regulation by the states. However, state departments of insurance are increasing their oversight of PBM activities due to legislation passing in nearly all states requiring PBMs to register or obtain a license with the department, authorizing agencies to conduct market conduct examinations and other audits of our licensed entities. In addition, rulemaking in a number of states expands the underlying statutory law particularly with respect to the scope of application to pharmacy appeals and reimbursement, transparency reporting, PBM compensation, network design, member cost sharing and pharmacy audits.

Pharmacy Network Access Legislation - Medicare Part D and a majority of states now have some form of legislation affecting the Company's (and its health plans' and its health plan clients') ability to limit access to a pharmacy provider network or remove pharmacy network providers. For example, certain "any willing provider" legislation may require the Company or its clients to admit a nonparticipating pharmacy if such pharmacy is willing and able to meet the plan's price and other applicable terms and conditions for network participation. These laws could negatively affect the services and economic benefits achievable through a limited pharmacy provider network. Several states apply these laws to the administration of plans that are not typically subject to such laws, *e.g.* national and multi-state ERISA self-funded plans. Also, a majority of states have some form of legislation affecting the Company's ability (and the Company's and its client health plans' ability) to conduct audits of network pharmacies regarding claims submitted to the Company for payment. These laws could negatively affect the Company's ability to recover overpayments of claims submitted by network pharmacies that the Company identifies through pharmacy audits. Finally, several states have passed legislation that limits the ability of PBMs and health insurers to provide special benefit structures for use with affiliated pharmacies, which could result in reduced savings to clients and consumers. One state has passed and others are considering legislation prohibiting licensure of pharmacies affiliated with a PBM.

Pharmacy Pricing Legislation - Multiple states have passed legislation regulating the Company's ability to manage pricing practices, including mandated pharmacy reimbursement rates and the collection of transmission fees. A number of states have also established 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. Some states now require the PBM to reimburse a pharmacy's actual acquisition cost. These laws could negatively affect the Company's ability to establish MAC prices for generic drugs. Additionally, some states have passed legislation that would restrict certain types of retroactive reconciliation or recoupment from pharmacies in the network or create a reimbursement benchmark mandate, such as the national average drug acquisition cost and/or the wholesale acquisition cost ("WAC"), plus a set dispensing fee, for pharmacies in the network.

Formulary and Plan Design Regulation - A number of government entities regulate the administration of prescription drug benefits. HHS regulates how Medicare Part D formularies are developed and administered, including requiring the inclusion of all drugs in certain classes and categories, subject to limited exceptions. Under the ACA, CMS imposes drug coverage requirements for health plans required to cover essential health benefits, including plans offered through federal or state Public Exchanges. Additionally, the NAIC and health care accreditation agencies like NCQA and URAC have developed model acts and standards for formulary development that are often incorporated into government requirements. Many states regulate the scope of prescription drug coverage, as well as the delivery channels to receive prescriptions, for insurers, MCOs and Medicaid managed care plans. The increasing government regulation of formularies could significantly affect the Company's ability to

develop and administer formularies, pharmacy networks and other plan design features. Similarly, some states prohibit health plan sponsors from implementing certain restrictive pharmacy benefit plan design features. This regulation could limit or preclude (i) limited networks, (ii) a requirement to use particular providers, (iii) copayment differentials among providers and (iv) formulary tiering practices.

Corporate Practice of Medicine - The Company is subject to various state laws, regulations and legal and administrative decisions that restrict the corporate practice of medicine and fee splitting. The corporate practice of medicine doctrine generally prohibits corporate entities from practicing medicine or employing physicians (and, in some cases, other providers) to provide professional medical services. The doctrine reflects a variety of historical public policy concerns, including concerns that (a) allowing corporations to practice medicine or employ physicians will result in the commercialization of the practice of medicine, (b) a corporation's obligation to its shareholders may not align with a physician's obligation to his/her patients and (c) employment of a physician by a corporation may interfere with the physician's independent medical judgment. While many states have some form of the corporate practice of medicine doctrine, the scope and enforcement varies widely. In those states where the doctrine exists, it typically arises from the state's medical practice act, but has been shaped over the years by state statutes, regulations, court decisions, attorney general opinions and actions by state medical licensing boards. In addition, some states may have corporate practice restrictions that apply to other providers, such as nurse practitioners and physician assistants.

Historically, the medical profession has recognized an ethical prohibition against physicians (and often other providers) paying professional peers and others for referrals and fee splitting. Fee splitting generally occurs when a physician splits part of the professional fee earned from treating a referred patient with the source of the referral. Among the public policy harms that have been cited in support of fee splitting prohibitions are (a) unnecessary medical services, and (b) incompetent specialists. In response to these legitimate concerns, many states have adopted prohibitions against fee splitting. States have taken a variety of legislative approaches to fee splitting, from near complete bans, to bans with various exceptions, to no prohibition at all. Some of the prohibitions have a broad reach and also prohibit otherwise legitimate business relationships with entities that are not health care providers, such as billing agencies or management companies.

Legal structures have been developed to comply with various state corporate practice of medicine and fee splitting laws. The "captive" or "friendly" professional corporation model allows a legal entity (typically a professional corporation or professional limited liability company) whose shareholders are all physicians to employ the physicians (and other providers). The physician entity then contracts with a corporate entity referred to as a management services organization ("MSO") to provide various management services. The physician entity is kept "friendly" through a stock transfer restriction agreement and/or other relationship between the MSO and the physician owners of the professional corporation. The fees under the management services arrangement must be carefully structured to comply with state fee splitting laws, which in some states may prohibit percentage-based fees.

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

Laws and Regulations Related to the Pharmacy & Consumer Wellness 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 & Consumer Wellness segment specifically, including laws and regulations that limit the sale of alcohol, mandate a minimum wage, govern the practices of optometry or audiology, or impact the provision of dietician services and the sale of durable medical equipment, contact lenses, eyeglasses and hearing aids.

Available Information

CVS Health Corporation was incorporated in Delaware in 1996. The corporate office is located at One CVS Drive, Woonsocket, Rhode Island 02895, telephone (401) 765-1500. CVS Health Corporation's common stock is listed on the New York Stock Exchange under the trading symbol "CVS." General information about the Company is available through the Company's website at *http://www.cvshealth.com*. The Company's financial press releases and filings with the SEC are available free of charge within the Investors section of the Company's website at *http://investors.cvshealth.com*. In addition, the SEC maintains an Internet site that contains reports, proxy and information statements and other information regarding issuers, such as the Company, that file electronically with the SEC. The address of that website is *http://www.sec.gov.* The information on or

linked to the Company's website is neither a part of nor incorporated by reference in this 10-K or any of the Company's other SEC filings.

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

Item 1A. Risk Factors.

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

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

Summary

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

Risks Relating to Our Businesses

- We may not be able to accurately forecast health care and other benefit costs.
- Adverse economic conditions in the U.S. and abroad can materially and adversely impact our businesses, operating results, cash flows and financial condition.
- Each of our segments operates in a highly competitive and evolving business environment.
- A change in our Health Care Benefits product mix may adversely affect our profit margins.
- Our health care delivery businesses face unique risks.
- Negative public perception of the industries in which we operate can adversely affect our businesses, operating results, cash flows and prospects.
- We must maintain and improve our relationships with our retail and specialty pharmacy customers and increase the demand for our products and services.
- We face risks relating to the availability, pricing and safety profiles of prescription drugs that we purchase and sell.
- The reserves we hold for expected claims in our Insured Health Care Benefits products are based on estimates that involve an extensive degree of judgment and are inherently variable, and any reserve, including a premium deficiency reserve, may be insufficient.
- We may pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities, as well as strategic divestitures, which may be unsuccessful, cause us to assume unanticipated liabilities, disrupt our existing businesses, be dilutive or lead us to assume significant debt, among other things.

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

- We are subject to potential changes in public policy, laws and regulations, including reform of the U.S. health care system and entitlement programs.
- If we fail to comply with applicable laws and regulations, or fail to change our operations in line with any new legal or regulatory requirements, we could be subject to significant adverse regulatory actions.
- If our compliance or other systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to contractual damages, regulatory actions and/or litigation.
- We routinely are subject to litigation and other adverse legal proceedings, including class actions and *qui tam* actions. Many of these proceedings seek substantial damages which may not be covered by insurance.
- We frequently are subject to regular and special governmental audits, investigations and reviews that could result in changes to our business practices and also could result in material refunds, fines, penalties, civil liabilities, criminal liabilities and other sanctions.
- We may face increased regulatory risks related to our vertical integration strategy, such as legislation prohibiting state licensure of pharmacies affiliated with a PBM.
- We face unique regulatory and other challenges in our PBM, Medicare and Medicaid businesses.
- Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues, and any disruption to funding from the U.S. federal government could adversely impact our revenues and operating results.
- We may not be able to obtain adequate premium rate increases in our Insured Health Care Benefits products, which would have an adverse effect on our revenues, MBRs and operating results, and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes.
- Minimum MLR rebate requirements limit the level of margin we can earn in our Insured Health Care Benefits products while leaving us exposed to higher than expected medical costs. Challenges to our minimum MLR rebate methodology and/or reports could adversely affect our operating results.
- Our operating results may be adversely affected by changes in laws and policies governing employers and by union organizing activity.

Risks Related to Our Operations

- Data governance failures, the failure or disruption of our information technology or infrastructure, a cyberattack or other information security incident can adversely affect our reputation, businesses and prospects. Our use and disclosure of members', customers' and other constituents' personal information is subject to complex regulations. The use of AI and related technology may also increase exposure to reputational, cybersecurity, data privacy, legal, regulatory and operational risks.
- Product liability, product recall, professional liability or personal injury issues could damage our reputation.
- We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success.
- Sales of our products and services are dependent on our ability to attract and motivate internal sales personnel and independent third-party brokers, consultants and agents. We may be subject to penalties or other regulatory actions as a result of the marketing practices of brokers and agents selling our products.
- Failure of our businesses to effectively collaborate could prevent us from maximizing our operating results.
- We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.
- Both our and our vendors' operations are subject to a variety of business continuity hazards and risks that could interrupt our operations or otherwise adversely affect our performance and operating results.

Financial Risks

- We would be adversely affected by downgrades or potential downgrades in our credit ratings, should they occur, or if we do not effectively deploy our capital.
- Goodwill and other intangible assets could, in the future, become impaired.
- Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative instruments and other investments.

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

- We face risks relating to the market availability, pricing, suppliers and safety profiles of prescription drugs and other products that we purchase and sell.
- Continuing consolidation and integration among providers and other suppliers may increase our costs and increase competition.

Risks Relating to Our Businesses

We may not be able to accurately forecast health care and other benefit costs, including as a result of pandemics or disease outbreaks, which could adversely affect our Health Care Benefits segment's operating results. There can be no assurance that future health care and other benefit costs will not exceed our projections.

Premiums for our Insured Health Care Benefits products are priced in advance based on our forecasts of health care and other benefit costs during a fixed premium period, which is generally twelve months. These forecasts are typically developed several months before the fixed premium period begins, are influenced by historical data (and recent historical data in particular), are dependent on our ability to anticipate and detect medical cost trends and changes in our members' behavior and health care utilization patterns and medical claim submission patterns and require a significant degree of judgment. For example, our revenue on Individual Medicare policies is based on bids submitted in June of the year before the contract year. Cost increases in excess of our projections cannot be recovered in the fixed premium period through higher premiums. As a result, our profits are particularly sensitive to the accuracy of our forecasts of the increases in health care and other benefit costs that we expect to incur and our ability to anticipate and detect medical cost trends. During periods when health care and other benefit costs, utilization and/or medical costs trends experience significant volatility and medical claim submission patterns are changing rapidly, accurately detecting, forecasting, managing, reserving and pricing for our (and our self-insured customers') medical cost trends and incurred and future health care and other benefit costs is more challenging. There can be no assurance regarding the accuracy of the health care or other benefit cost projections reflected in our pricing, and whether our health care and other benefit costs will be affected by pandemics, disease outbreaks and other external events over which we have no control. Even relatively small differences between predicted and actual health care and other benefit costs as a percentage of premium revenues can result in significant adverse changes in our Health Care Benefits segment's operating results.

A number of factors contribute to rising health care and other benefit costs, including previously uninsured members entering the health care system; Medicare members' utilization of supplemental benefits; other changes in members' behavior, health care utilization patterns and utilization management; turnover in our membership, health care provider and member fraud; additional government mandated benefits or other regulatory changes, including changes to or as a result of the ACA and IRA; changes in the health status of our members; the aging of the population and other changing demographic characteristics; advances in medical technology; increases in the number and cost of prescription drugs (including specialty pharmacy drugs and ultra-high cost drugs and therapies); direct-to-consumer marketing by drug manufacturers; the increasing influence of social media on our members' health care utilization and other behaviors; the shift to a consumer-driven business model; changes in health care practices and general economic conditions (such as inflation and employment levels); increases in labor costs; pandemics, epidemics or disease outbreaks; influenza-related health care costs (which may be substantial and higher than we expected); clusters of high-cost cases; natural disasters and extreme weather events (which may increase in frequency or intensity as a result of climate change); and numerous other factors that are or may be beyond our control. For example, the length and severity of the influenza season can have an impact on health care and other benefit costs. 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 benefit costs over time, and future amendments to the ACA that increase the uninsured population may amplify this issue.

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

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

periods when health care and other benefit costs, utilization and/or medical cost trends experience significant volatility and medical claim submission patterns are changing rapidly. Such risks are further magnified by the ACA and other existing and future legislation and regulations that limit our ability to price for our projected and/or experienced increases in utilization and/or medical cost trends.

Adverse economic conditions in the U.S. and abroad can materially and adversely impact our businesses, operating results, cash flows and financial condition.

Adverse economic conditions in the U.S. and abroad, including those caused by inflation, high interest rates, declines in consumer confidence, increases in unemployment and supply chain disruptions, all of which we have experienced over the last number of years, can materially and adversely impact our businesses, operating results, cash flows and financial condition, including:

- In our Health Care Benefits segment, by causing unanticipated increases and volatility in utilization of covered services, increases in fraudulent claims and disputes, changes in medical claim submission patterns and/or increases in medical unit costs and/or provider behavior as hospitals and other providers attempt to maintain revenue levels in response to economic conditions, each of which would increase our costs and limit our ability to accurately detect, forecast, manage, reserve and price for our (and our self-insured customers') medical cost trends and incurred and future health care and other benefit costs; causing customers and potential customers of our Health Care Benefits segment, particularly smaller employers and individuals, to forgo obtaining or renewing their health and other coverage with us; and also affect our ability to profitably grow and diversify our Health Care Benefits membership.
- In our Health Services segment, by causing drug utilization to decline, reducing demand for PBM services and adversely affecting the financial health of our PBM clients.
- In our Pharmacy & Consumer Wellness segment, by causing drug utilization to decline, changing consumer purchasing power, preferences and/or spending patterns leading to reduced consumer demand for products sold in our stores, potentially increasing levels of theft at our retail locations.
- By causing our existing customers to reduce workforces (including due to business failures), which would reduce our revenues, the number of covered lives in our PBM clients and/or the number of members our Health Care Benefits segment serves. Reductions in workforce by our customers can also cause unanticipated increases in the health care and other benefit costs of our Health Care Benefits segment. For example, our business associated with members who have elected to receive benefits under Consolidated Omnibus Budget Reconciliation Act (known as "COBRA") typically has an MBR that is significantly higher than our overall Commercial MBR.
- By affecting the ability of our customers to obtain adequate financing, which could result in an inability of our customers to pay timely, or at all, the amounts owed to us.
- By causing both state and federal government payers, as a result of budget deficits or spending reductions, to suspend or seek to reduce their health care expenditures resulting in our customers delaying payments to us or renegotiating their contracts with us.
- By causing our clients and customers and potential clients and customers, particularly those with the most employees or members, and state and local governments, to force us to compete more vigorously on factors such as price and service, including service, discount and other performance guarantees, to retain or obtain their business.
- By causing members and other consumers to 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.
- By causing an increase in the prevalence of high-deductible health plans and health plan designs favoring co-insurance over co-payments.
- By weakening the ability or perceived ability of the issuers and/or guarantors of the debt or other securities we hold in our investment portfolio to perform on their obligations to us, which could result in defaults in those securities and has reduced, and may further reduce, the value of those securities and has created, and may continue to create, net realized capital losses for us that reduce our operating results.
- By causing customers, including self-insured customers in our Health Care Benefits segment, medical members, medical providers and the other companies to be unable to perform their obligations to us which could reduce our operating results.
- By affecting our ability to obtain necessary financing on acceptable terms, our ability to secure suitable store locations under acceptable terms.
- By weakening the ability of our former subsidiaries and/or their purchasers to satisfy their lease obligations that we have guaranteed and causing the Company to be required to satisfy those obligations.

- By weakening the financial condition of other insurers, including long-term care insurers and life insurers, which increases the risk that we will receive significant assessments for obligations of insolvent insurers to policyholders and claimants.
- By continuing to cause inflation that could cause interest rates to further increase and thereby further increase our interest expense and reduce our operating results, as well as further decrease the value of the debt securities we hold in our investment portfolio, which would further reduce our operating results and/or adversely affect our financial condition.

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

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

- As competition increases in the geographies in which we operate, including competition from new entrants, a significant increase in price compression and/or reimbursement pressures could occur, and this could require us to reevaluate our pricing structures to remain competitive.
- In our Health Care Benefits segment, we must often bid against our competitors in a highly competitive environment to acquire and retain our government customers' business. Winning bids for Medicaid and dual eligible programs often are challenged successfully by unsuccessful bidders, and may also be withdrawn or canceled by the issuing agency. CMS has proposed requiring that health plans offering certain dual eligible programs must also offer Medicaid programs, which has resulted in the Company refraining from bidding in certain jurisdictions and could further impact the Company's ability to obtain or retain membership in its dual eligible programs.
- In our Health Care Benefits segment, our customers have considerable flexibility in moving between us and our competitors. We may lose members to competitors with more favorable pricing, or our customers may purchase different types of products from us that are less profitable, adversely affecting our revenues and operating results. In addition, our Medicare, Medicare Advantage, Medicaid and CHIP products may be 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 operating results.
- Our Health Care Benefits segment's operating results and competitiveness is heavily impacted, in the case of Medicaid programs, by the sufficiency of the rates the states determine are actuarially sound based on experience from previous years. Such rate levels may not be representative of actual experience, and insufficient rates will negatively impact our revenues and operating results.
- From time to time we request increases in our premium rates in our Commercial Health Care Benefits business in order to adequately price for projected medical cost trends, required expansions of coverage and rating limits, and significant assessments, fees and taxes imposed by federal and state governments, including as a result of the ACA. Our rates also must be adequate to reflect the risk that our products will be selected by people with a higher risk profile or utilization rate than the pool of participants we anticipated when we established pricing for the applicable products (also known as "adverse selection"), particularly in small group Commercial products. These rate increases may be significant and thus heighten the risks of adverse publicity, adverse regulatory action and adverse selection and the likelihood that our requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.
- The competitive success of our Health Services segment is dependent on our ability to establish and maintain contractual relationships with network pharmacies.
- The competitive success of our Pharmacy & Consumer Wellness segment and our specialty pharmacy operations is dependent on our ability to establish and maintain contractual relationships with PBMs and other payors on acceptable terms as the payors' clients evaluate adopting narrow or restricted retail pharmacy networks.
- In our PBM business, we maintain contractual relationships with brand name drug manufacturers that provide for purchase discounts and/or rebates on drugs dispensed by pharmacies in our retail network and by our specialty and mail order pharmacies (all or a portion of which may be passed on to clients). Manufacturer's rebates often depend on a PBM's ability to meet contractual requirements, including the placement of a manufacturer's products on the PBM's formularies. If we lose our relationship with one or more drug manufacturers, or if the discounts or rebates provided by drug manufacturers decline, our operating results, cash flows and/or prospects could be adversely affected.
- If laws or regulations are promulgated that limit the number of PBMs available in a particular business or geography, competition in those businesses and geographies could be amplified and could adversely affect our revenues and operating results.
- The PBM industry has been experiencing price compression as a result of competitive pressures and increased client demands for lower prices; pricing guarantees; increased revenue sharing, including sharing in a larger portion of payments, including rebates and fees, to PBMs and group purchasing organizations received from drug manufacturers; enhanced

service offerings and/or higher service levels. Marketplace dynamics and regulatory changes also have adversely affected our ability to offer plan sponsors pricing that includes the use of retail "differential" or "spread," which could adversely affect our future profitability, and we expect these trends to continue.

- Our retail pharmacy and specialty pharmacy operations have been affected by reimbursement pressure caused by competition, including client demands for lower prices, generic drug pricing, earlier than expected generic drug introductions and network reimbursement pressure. If we are unable to increase our prices to reflect, or otherwise mitigate the impact of, increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose customers to competitors with more favorable pricing, adversely affecting our revenues and operating results.
- A shift in the mix of our pharmacy prescription volume towards programs offering lower reimbursement rates as a result of competition or otherwise could adversely affect our margins, including the ongoing shift in pharmacy mix towards 90-day prescriptions at retail and the ongoing shift in pharmacy mix towards Medicare Part D prescriptions.
- PBM client contracts often are for a period of approximately three years. However, PBM clients may require early or periodic re-negotiation of pricing prior to contract expiration. PBM clients are generally well informed, can move between us and our competitors and often seek competing bids prior to expiration of their contracts. We are therefore under pressure to contain price increases despite being faced with increasing drug costs and increasing operating costs. If we are unable to increase our prices to reflect, or otherwise mitigate the impact of, increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose customers to competitors with more favorable pricing, adversely affecting our revenues and operating results.
- Direct-to-consumer ("DTC") sales of prescription drugs by pharmaceutical companies is a growing trend in the United States. By implementing DTC sales platforms, pharmaceutical companies can advertise, or sell, their own branded drugs directly to patients, bypassing traditional distribution channels and intermediaries, including pharmacies and PBMs. DTC platforms may also increase demand for expensive, brand-name drugs that may not provide significant clinical benefit over more cost-effective alternatives. As a result, the DTC trend may increase overall health care costs for consumers and adversely impact the performance of the Company's Pharmacy & Consumer Wellness and Health Services segments.

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

Disruptive innovation by existing or new competitors has altered, and is expected to continue to alter, the competitive landscape in the future and require us to accurately identify and assess such alterations and make timely and effective changes to our strategies and business model to compete effectively. For example, decisions to buy our Health Care Benefits and Health Services products and services increasingly are made or influenced by consumers, either through direct purchasing (e.g., Medicare Advantage plans and PDPs) or through public exchanges and private health insurance exchanges that allow individual choice. To compete effectively in the consumer-driven marketplace, we will be required to develop or acquire new capabilities, attract new talent and develop new service and distribution relationships that respond to consumer needs and preferences.

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

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

Our Insured Health Care Benefits products that involve greater potential risk generally tend to be more profitable than our ASC products, but ASC products continue to rise in popularity. We also serve, and expect to grow our business with, government-sponsored programs, including Medicare and Medicaid, that are subject to competitive bids, have lower profit margins than our Commercial Insured Health Care Benefits products and may introduce volatility in our cash flows from time to time. A continuing shift of enrollees from more profitable products to less profitable products could have a material adverse effect on the Health Care Benefits segment's operating results.

Our Health Care Delivery businesses face unique risks.

Our health care delivery businesses, which include health risk assessments and primary care services, including senior-focused value-based primary care services for Medicare eligible patients, face unique risks which include, but are not limited to, the following:

- ability to recruit, retain and grow a network of credentialed, high-quality physicians, physician assistants and nurse practitioners to provide clinical services in highly competitive markets for talent, especially in light of possible changes to the U.S. immigration policies, rules, laws or orders;
- successful challenges to the treatment of certain health care providers as independent contractors in many states, which could result in increased costs and subject the business to regulatory sanction;
- dependence on a concentrated number of key health plan customers;
- the quality of the information received about plan members of such health plans for whom Signify Health will seek to provide in-home evaluations and other services, and the regulatory restrictions and requirements associated with directly contacting plan members;
- ability to perform and ensure the quality of health risk assessments;
- ability to achieve and receive shared health care cost savings;
- the regulatory and business risks associated with participation in certain government health care programs and identification of diagnosis codes related to risk adjustment payments under Part C of the Medicare program;
- health reform initiatives and changes in the rules governing government health care programs, including rules related to the use of in-home health risk assessments for the purpose of capturing individual risk used to calculate an individual's risk adjustment factor or a change to how patient-level risk is determined for CMS programs;
- use of "open source" software in its technology, which may make it easier for others to gain access or compromise its proprietary technology;
- ability to attract new patients, including Medicare-eligible patients, in a highly competitive market;
- satisfying the enrollment requirements under government health care programs for physicians and other providers in a timely manner;
- dependence on a significant portion of revenue from Medicare or Medicare Advantage plans, which subjects Oak Street Health to reductions in Medicare reimbursement rates or changes in the rules governing the Medicare program;
- dependence for a significant portion of revenue from agreements with a limited number of key payors with whom Oak Street Health contracts to provide services under terms that may permit a payor to amend the compensation arrangements or terminate the agreements without cause;
- dependence on reimbursements from third-party payors, which can result in substantial delay, and on patients, through copayments and deductibles, which subjects the Company to additional reimbursement risk;
- under the fixed fee (or capitated) agreements Oak Street Health enters into with health plans, the assumption of the risk that the actual cost of a service it provides to a patient exceeds the reimbursement provided by the health plan;
- reductions in the quality ratings of Medicare health plans the Company serves could result in a shift of patients from, or the termination of, a health plan the Company serves;
- submission of inaccurate, incomplete or erroneous data, including risk adjustment data, to health plans and government payors could result in inaccuracies in the revenue recorded or receipt of overpayments, which may subject the Company to repayment obligations and penalties;
- geographic concentration of primary care centers;
- laws regulating the corporate practice of medicine and the associated agreements entered into with physician practice groups restrict the manner in which the Oak Street Health business is able to direct the operations and otherwise exercise control of its physician practice groups;
- changes in the legal treatment of contractual arrangements with physician practice groups could impact the ability to consolidate the revenue of these groups; and
- ability to maintain and enhance reputation and brand recognition.

The additional risks faced by our health care delivery businesses may also compound, or be heightened by, many of our other risks, including the risks related to adverse economic conditions in the U.S. and abroad, cybersecurity and compliance with applicable laws and regulations, among others.

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

Our brand and reputation are two of our most important assets, and the industries in which we operate have been and are negatively perceived by the public from time to time. Negative publicity may come as a result of adverse media coverage, litigation against us and other industry participants, the ongoing public debates over drug pricing, PBMs, government

involvement in drug pricing and purchasing, changes to the ACA, governmental hearings and/or investigations, actual or perceived shortfalls regarding our industries' or our own products, including Medicare Advantage plans in general, and/or business practices (including PBM operations, drug pricing and insurance coverage determinations) and social media and other media relations activities. Negative publicity also may come from a failure to meet customer expectations for consistent, high quality and accessible care. This risk may increase as we continue to offer products and services that make greater use of data and as our business model becomes more focused on delivering health care to consumers.

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

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

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

The success of our businesses depends in part on customer loyalty, superior customer service and our ability to persuade customers to frequent our retail stores and online sites and to purchase products in additional categories and our proprietary brands. Failure to timely identify or effectively respond to changing consumer preferences, spending patterns and evolving demographic mixes in the communities we serve, including shifts toward online shopping, or failure to maintain desirable selections of merchandise, store environments or guest experiences could adversely affect our relationship with our customers and clients and the demand for our products and services and could result in excess inventories of products.

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

We also could be adversely affected if we fail to identify or effectively respond to changes in marketplace dynamics. For example, specialty pharmacy represents a significant and growing proportion of prescription drug spending in the U.S., a significant portion of which is dispensed outside of traditional retail pharmacies. Because our specialty pharmacy business focuses on complex and high-cost medications, many of which are made available by manufacturers to a limited number of pharmacies (so-called limited distribution drugs) that serve a relatively limited universe of patients, the future growth of our specialty pharmacy business depends largely upon expanding our access to key drugs and penetration in certain treatment categories. Any contraction of our base of patients or reduction in demand for the prescriptions we currently dispense could have an adverse effect on our specialty pharmacy business, operating results and cash flows.

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

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

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

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

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

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

Our estimates of health care costs payable are based on a number of factors, including those derived from historical claim experience, but this estimation process also makes use of extensive judgment. Considerable variability is inherent in such estimates, and the accuracy of the estimates is highly sensitive to changes in medical claims submission and processing patterns and/or procedures, turnover and other changes in membership, changes in product mix, changes in the utilization of medical and/or other covered services, including prescription drugs, changes in medical cost trends, changes in our medical management practices and the introduction of new benefits and products. We estimate health care costs payable periodically, and any resulting adjustments, including premium deficiency reserves, are reflected in current-period operating results within health care costs. For example, during the first quarter of 2025, we recorded a premium deficiency reserve of $448 million related to our individual exchange product line and during the second quarter of 2025, we recorded a premium deficiency reserve of $471 million related to our Group Medicare Advantage product line within the Health Care Benefits segment, primarily related to anticipated losses for the remainder of the 2025 coverage year. 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, 2025 would cause these estimates to change in the near term, and such a change could be material.

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

Extreme events, or the threat of extreme events, could materially impact our businesses.

The occurrence of natural disasters or extreme weather events, such as hurricanes, tropical storms, floods, wildfires, earthquakes, tsunamis, cyclones, typhoons, extended winter storms, droughts, tornadoes, epidemics, pandemics or disease outbreaks and other extreme events and man-made disasters, such as nuclear or biological attacks or other acts of violence, such

as active shooter situations, whether as a result of war or terrorism or otherwise, can have a material adverse effect on the U.S. economy in general, our industries, our vendors and us specifically. In particular, the long-term effects of climate change are expected to be widespread and unpredictable.

Extreme events or the threat of extreme events could result in significant health care costs, including those associated with behavioral health offerings, waiving certain medical requirements or assisting with replacement medications or transfer prescriptions, which could also be affected by the government's actions and the responsiveness of public health agencies and other insurers. Such events could materially and adversely affect our businesses, operations, operating results and cash flows.

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

We may be unable to achieve our corporate responsibility and sustainability goals.

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

Further, an increasing percentage of colleagues, customers, stockholders and other stakeholders consider corporate social responsibility and sustainability factors in making employment, consumer health care and investment decisions. If we are unable to meet our goals, we may have difficulty retaining or attracting colleagues, investors, customers, or partners or competing effectively, which would negatively impact our brand and reputation, as well as our business, operating results, and financial condition.

In addition, we could face increased regulatory, reputational and legal scrutiny as a result of our corporate social responsibility and sustainability related commitments and disclosures, and we could also face challenges with managing conflicting regulatory requirements and our various stakeholders' expectations.

We may pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities, as well as strategic divestitures, 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 pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities, as well as strategic divestitures, as part of our business strategy. Some other risks we may face with respect to acquisitions and other inorganic growth strategies include:

- we may not be able to obtain the required regulatory approval for an acquisition in a timely manner, if at all;
- the acquired, alliance and/or joint venture businesses may not perform as projected;
- the goodwill or other intangible assets established as a result of our acquisitions may be incorrectly valued or may become impaired;
- we may assume unanticipated liabilities, including those that were not disclosed to us or which we underestimated;
- the acquired businesses, or the pursuit of other inorganic growth strategies, could disrupt or compete with our existing businesses, distract management, result in the loss of key employees, business partners, suppliers and customers, divert

resources, result in tax costs or inefficiencies and make it difficult to maintain our current business standards, controls, information technology systems, policies, procedures and performance;
- we may finance future acquisitions and other inorganic growth strategies by issuing common stock for some or all of the purchase price, which would dilute the ownership interests of our stockholders;
- we may incur significant debt in connection with acquisitions (whether to finance acquisitions or by assuming debt from the businesses we acquire);
- a proposed or pending transaction may have a negative effect on the Company's credit ratings;
- we may enter into merger or purchase agreements but, due to reasons within or outside our control, fail to complete the related transactions, which could result in termination fees or other penalties that could be material, cause material disruptions to our businesses and operations and adversely affect our brand, reputation or stock price;
- we may be involved in litigation related to mergers or acquisitions, including for matters that occurred prior to the applicable closing, which may be costly to defend and may result in adverse rulings against us that could be material;
- announcements related to an acquisition could have an adverse effect on the market price of the Company's common stock and other securities; 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.

Similarly, we may also seek to divest assets that no longer fit into our long-term strategic plan. Such divestitures may take time and, even if such divestitures can be completed, the terms of such divestitures will be subject to market conditions, financing availability and other considerations of potential buyers, and they may have negative short-term financial impacts on us. In addition, joint ventures present risks that are different from acquisitions, including selection of appropriate joint venture parties, initial and ongoing governance of the joint venture, joint venture compliance activities (including compliance with applicable CMS requirements), growing the joint venture's business in a manner acceptable to all the parties, including other providers in the networks that include joint ventures, maintaining positive relationships among the joint venture parties and the joint venture's customers, and member and business disruption that may occur upon joint venture termination.

Upon the closing of any acquisition, we need to successfully integrate the products, services and related assets, as well as internal controls into our business operations. If an acquisition is consummated, the integration of the acquired business, its products, services and related assets into our company also may be complex, expensive, and time-consuming and, if the integration is not fully successful, we may not achieve the anticipated benefits, operating and cost synergies and/or growth opportunities of an acquisition. An inability to realize the full extent of the anticipated benefits, operating and cost synergies, innovations and operations efficiencies or growth opportunities of an acquisition, as well as any delays or additional expenses encountered in the integration process, could have a material adverse effect on our businesses and operating results.

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

We are subject to potential changes in public policy, laws and regulations, including reform of the U.S. health care system and entitlement programs, which could have a material adverse effect on our businesses, operations and/or operating results.

The political environment in which we operate remains uncertain. It is reasonably possible that our business operations and operating results could be materially adversely affected by legislative, enforcement, regulatory and public policy changes at the federal or state level, including, but not limited to: changes to the regulatory environment for health care and related benefits, including Medicare, Medicare Advantage, the ACA, and related regulations; changes in the 340B program, including the resumption of the Pilot and any expansion thereof; efforts to amend the ACA and related regulations, including through litigation aimed at challenging the ability to enforce portions of the ACA, such as the preventative services mandate; changes to laws or regulations governing drug reimbursement, pricing, purchasing and/or importation; changes to or adoption of laws or regulations governing PBMs, including those related to prohibiting pharmacy licensure for pharmacies affiliated with a PBM, network restrictions, formulary management, affiliate reimbursement, contractual guarantees and reconciliations, reimbursement mandates, required reporting, compensation, purchase discount and/or rebate arrangements with drug manufacturers and/or other PBM services; changes to the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs; changes to or adoption of laws and/or regulations relating to claims processing and billing; changes to immigration policies; changes to patent laws; changes with respect to tax and trade policies, tariffs and other government regulations affecting trade between the U.S. and other countries; and other public policy initiatives.

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, expand fiduciary obligations, impose medical or bad faith

liability, increase our responsibilities under ERISA or the remedies available under ERISA, or reduce the scope of ERISA and Medicare Part D preemption of state law claims or (ii) other legislation and regulations. For example, laws in Arkansas, Louisiana, North Dakota and Oklahoma have attempted to limit PBM practices and have been subject to recent lawsuits. Additional litigation has been filed in several states to challenge ERISA and Medicare Part D preemption.

It is not possible to predict the enactment or content of new legislation or regulations or changes to existing laws or regulations or their enforcement, interpretation or application, or the form they will take (for example, through the use of U.S. Presidential Executive Orders or executive orders by governors or key regulators). If we fail to respond adequately to such changes, including by implementing strategic and operational initiatives, or do not respond as effectively as our competitors, our businesses, operations and operating results may be materially adversely affected. Even if we could predict such matters, it may not be possible to eliminate the adverse impact of public policy changes that would fundamentally change the dynamics of one or more industries in which we compete. Examples of such changes include, but are not limited to: the federal or one or more state governments fundamentally restructuring or reducing the funding available for government programs, increasing its involvement in drug reimbursement, pricing, purchasing and/or importation, changing the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, changing the tax treatment of health or related benefits, including the expiration of enhanced premium tax credits, or significantly altering the ACA. The likelihood of adverse changes remains high due to state and federal budgetary pressures, and our businesses and operating results could be materially and adversely affected by such changes, even if we correctly predict their occurrence.

There is also uncertainty surrounding potential changes to the health care regulatory environment in the U.S. For example, potential efforts to reform federal government processes and reduce expenditures as well as pressures on and uncertainty surrounding the U.S. federal government's budget and potential changes in budgetary priorities could adversely affect the funding for individual programs, including government programs, upon which our business depends. Executive orders covering health care and other subjects including immigration, AI, energy and the federal workforce as well as the workforce of public and private companies, if implemented through agency action, may also impact the Company. Potential regulatory changes related to tax, trade, economic and monetary policy and heightened diplomatic tensions or political and civil unrest, among other potential changes, could adversely impact the global economy and our operating results.

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

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

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

Certain of our Health Services and Pharmacy & Consumer Wellness operations, products and services are subject to:

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

Our Health Care Benefits products are highly regulated, particularly those that serve Medicare, Medicaid, dual eligible, dual eligible special needs and small group Commercial customers and members. The laws and regulations governing participation

in Medicare Advantage (including dual eligible special needs plans), Medicare Part D, Medicaid, and Managed Medicaid plans are complex, are subject to interpretation and can expose us to penalties for non-compliance.

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

In addition, we are subject to assessments under guaranty fund laws existing in all states for obligations of insolvent insurance companies (including long-term care insurers), HMOs, ACA co-ops and other payors to policyholders and claimants. Guaranty funds are maintained by state insurance commissioners to protect policyholders and claimants in the event that an insurer, HMO, ACA co-op and/or other payor becomes insolvent or is unable to meet its financial obligations. These funds are usually financed by assessments against insurers regulated by a state. Future assessments may have an adverse effect on our operating results and cash flows.

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 and dual eligible plans and other programs, our brand and reputation, and our operating results, cash flows and financial condition.

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

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

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

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

Our businesses are part of highly regulated industries whose participants frequently are subject to litigation and other adverse legal proceedings. We are currently subject to various litigation and arbitration matters, investigations, regulatory audits, inspections, government inquiries, and regulatory and other legal proceedings, both within and outside the U.S. Litigation is increasing as we execute our vertical integration strategy and expand our services along the continuum of health care. In addition, disputes over contracts could lead to litigation or pre-litigation settlements that could materially adversely affect our businesses, operating results and/or cash flows.

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

addition, some types of damages, like punitive damages, may not be covered by insurance, and in some jurisdictions the coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability also may become unavailable or prohibitively expensive in the future.

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

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

As one of the largest health care companies in the nation, we frequently are subject to regular and special governmental market conduct and other audits, investigations and reviews by, and we receive subpoenas and other requests for information from, various federal and state agencies, regulatory authorities, Attorneys General, committees, subcommittees and members of the U.S. Congress and other state, federal and international governmental authorities. CMS and the OIG also are auditing the risk adjustment-related data of certain of our Medicare Advantage plans. We are also receiving an increasing number of audits related to our PBM network reconciliation processes, and audits related to our use of prior authorization, which could result in reputational risks and changes to policies that may limit our use of prior authorization. The results of any audit 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, including by insurance brokers, and violations of patient privacy rights. The regulations and contractual requirements applicable to us and other industry participants are complex and subject to change, making it necessary for us to invest significant resources in complying with our regulatory and contractual requirements. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources. In addition, our medical costs and the medical expenses of our Health Care Benefits ASC customers may be adversely affected if we do not prevent or detect fraudulent activity by providers and/or members.

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

See “Legal and Regulatory Proceedings” in Note 18 ‘‘Commitments and Contingencies’’ included in Item 8 of this 10-K for additional information.

We may face increased regulatory risks related to our vertical integration strategy.

Our vertical integration strategy may lead to increased regulatory and public scrutiny as a result of consumer protection and quality of care concerns. In addition, there has been some new state legislative activity around prohibiting ownership or licensure of a pharmacy if it is affiliated with a PBM.

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

We face unique regulatory and other challenges that may inhibit the profitability of our Medicare and Medicaid businesses.

- In April 2025, CMS issued its final notice detailing final 2026 Medicare Advantage payment rates. Based on CMS’ notice, Medicare Advantage rates resulted in an expected average increase in revenue for the Medicare Advantage industry of 7.16%, which includes a risk score trend increase of 2.10%. Risk scores vary among Medicare Advantage plans depending

on the specific population served, so this increase does not represent an actual guaranteed payment increase. Without including the risk score trend increase, the 2026 rates result in an expected average increase in revenue for the Medicare Advantage industry of 5.06%, though the rates may vary widely depending on the provider group and patient demographics. On January 26, 2026, CMS issued an advance notice detailing proposed 2027 Medicare Advantage payment rates. The 2027 Medicare Advantage rates, if finalized as proposed, will result in an expected average increase in revenue for the Medicare Advantage industry of 2.54%, which includes a risk score trend increase of 2.45%. Without including the risk score trend increase, the advance 2027 rates will result in an expected average increase in revenue for the Medicare Advantage industry of 0.09%, though the rates may vary widely depending on the provider group and patient demographics. CMS intends to publish the final 2027 rate announcement no later than April 6, 2026. The Company faces challenges from the impact of the increasing cost of medical care (including prescription medications), changes to methodologies for determining payments 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. In addition, insufficient CMS Medicare rate increases relative to underlying medical cost trends may materially impact the results of our Oak Street Health business. We cannot predict how the rates will be finalized, future Medicare funding levels, the impact of future federal budget actions or ensure that such changes or actions will not have a material adverse effect on our Medicare operating results.

- The organic expansion of our Medicare Advantage and Medicare Part D service area is subject to the ability of CMS to process our requests for service area expansions and our ability to build cost competitive provider networks in the expanded service areas that meet applicable network adequacy requirements. CMS' decisions on our requests for service area expansions also may be affected adversely by compliance issues that arise each year in our Medicare operations.
- CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of the services we provide to our Medicare members, and state regulators are increasingly conducting audits to assess the quality of services we provide to our Medicaid members. As a result of these audits, we may be subject to significant or material retroactive adjustments to and/or withholding of certain premiums and fees, fines, criminal liability, civil monetary penalties, CMS- or state-imposed sanctions (including suspension or exclusion from participation in government programs) or other restrictions on our Medicare, Medicaid and other businesses, including suspension or loss of licensure.
- "Star ratings" from CMS for our Medicare Advantage plans will continue to have a significant effect on our plans' operating results. Only Medicare Advantage plans with a star rating of 4 or higher (out of 5) are eligible for a quality bonus in their basic premium rates. Based on the Company's membership as of December 2025, more than 81% of the Company's Medicare Advantage members were in 2026 Medicare Advantage plans that are rated 4 stars or higher and more than 63% of the Company's Medicare Advantage members were in a 4.5-star plan for 2026. CMS also gives PDPs star ratings that affect each PDP's enrollment. Medicare Advantage and PDP plans that are rated less than 3 stars for three consecutive years are subject to contract termination by CMS. CMS continues to change its rating system to make achieving and maintaining a four or higher star rating more difficult, including annual updates to performance measures. If our star ratings fall or remain below four for a significant portion of our Medicare Advantage membership, or do not match the performance of our competitors, or the star rating quality bonuses are reduced or eliminated, our revenues, operating results and cash flows may be significantly adversely affected. In addition, due to uncertainties with CMS cut-points, no Medicare Advantage plan can guarantee their overall star ratings. There can be no assurances that the Company will be successful in maintaining or improving its star ratings in future years.
- Payments we receive from CMS for our Medicare Advantage and Medicare Part D businesses also are subject to risk adjustment based on the health status of the individuals we enroll. Elements of that risk adjustment mechanism continue to be challenged by the DOJ, the OIG and CMS itself. For example, CMS made significant changes to the structure of the hierarchical condition category model in version 28, which may impact RAF scores for a larger percentage of Medicare Advantage beneficiaries and could result in changes to beneficiary RAF scores with or without a change in the patient's health status. CMS continuously evaluates how and where risk adjustment is captured, which from time-to-time has included the capture of diagnosis codes in home visits. A legislative or regulatory change to the ability of Medicare Advantage plans to use home visits as a means to evaluate and diagnose their members' health conditions, or substantial changes in the risk adjustment mechanism or other changes that may result from enforcement or audit actions, could: materially affect the amount of our Medicare reimbursement, require us to raise prices or reduce the benefits we offer to Medicare beneficiaries, impact the services provided by, or the financial performance of, Oak Street Health and Signify Health and potentially limit our (and the industry's) participation in the Medicare program.
- In May 2025, CMS announced it would audit every Medicare Advantage contract each payment year, with an expedited plan to complete audits for payment years 2018 through 2024 by early 2026. The lack of detail provided with respect to how CMS will select claims to audit and the methodology CMS will use may impact future Medicare Advantage bids and result in other implications.
- Our Medicare Part D operating results and our ability to expand our Medicare Part D business could be adversely affected if: the cost and complexity of Medicare Part D exceed management's expectations or prevent effective program

implementation or administration; further changes to the regulations regarding how drug costs are reported for Medicare Part D (including changes related to the IRA) are implemented in a manner that adversely affects the profitability of our Medicare Part D business; changes to the applicable regulations impact our ability to retain fees from third parties including network pharmacies; the government alters Medicare Part D program requirements or reduces funding because of the higher-than-anticipated cost to taxpayers of Medicare Part D or for other reasons; or reinsurance thresholds are reduced.

- The IRA contains significant changes to the Medicare Part D program, including changes that shift more of the claim liability to plans and away from the government, including a complete redesign of the Medicare Part D standard benefit effective in 2025, which may reduce the Company's flexibility to design competitive offerings.
- Further, as a result of the ACA and changes to the retiree drug subsidy rules, clients of our PBM business could decide to discontinue providing prescription drug benefits to their Medicare-eligible members. To the extent this phenomenon occurs, the adverse effects of increasing customer migration into Medicare Part D may outweigh the benefits we realize from growth of our Medicare Part D products.
- State Medicaid agencies regularly audit, and state officials regularly investigate, the Company's performance across all areas of its contractual obligations to the state to determine compliance and quality of services. The Company may be subject to, among other penalties, significant fines, sanctions, corrective actions, and enrollment freezes depending on the findings of these audits and reviews. The Company's ongoing performance and compliance with program requirements can impact our ability to expand and retain Medicaid business. State Medicaid agencies are also increasingly using the audit process to challenge the legality of PBM practices, such as guaranteed effective rate reconciliations with retail pharmacies and transmission fees.
- We have experienced challenges in obtaining complete and accurate encounter data for our Medicaid products due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, and some states mandate that certain amounts be included or excluded from encounter data, these difficulties could affect the Medicaid premium rates we receive and how Medicaid membership is assigned to us, which could have a material adverse effect on our Medicaid operating results and cash flows and/or our ability to bid for, and continue to participate in, certain Medicaid programs.
- If we fail to report and correct errors discovered through our own auditing procedures or during a CMS audit or otherwise fail to comply with the applicable laws and regulations, we could be subject to fines, civil monetary penalties or other sanctions, including fines and penalties under the False Claims Act, which could have a material adverse effect on our ability to participate in Medicare Advantage, Medicare Part D or other government programs, and on our operating results, cash flows and financial condition.
- Certain of our Medicaid contracts require the submission of complete and correct encounter data. The accurate and timely reporting of encounter data is increasingly important to the success of our Medicaid programs because more states are using encounter data to determine compliance with performance standards and, in part, to set premium rates. We have expended and may continue to expend additional effort and incur significant additional costs to collect accurate, or to correct inaccurate or incomplete, encounter data and have been and could be exposed to premium withholding, operating sanctions and financial fines and penalties for noncompliance.
- CMS has proposed requiring that health plans offering certain dual eligible programs must also offer Medicaid programs, which could further impact the Company's ability to obtain or retain membership in its dual eligible programs. In addition, states are increasingly requiring companies to offer Medicaid within a state and conducting competitive bid processes to qualify to offer dual eligible products.
- The "Working Families Tax Cut Act," formerly the "One Big Beautiful Bill Act," of 2025 makes changes to Medicaid eligibility rules and financing which will lead to reduced eligibility for Medicaid beneficiaries, particularly expansion populations, and reduced state funding, which will impact Medicaid benefits and payment rates. Given these changes, states that have not already done so are unlikely to consider Medicaid expansion.

Programs funded in whole or in part by the U.S. federal government are particularly sensitive to reduced government funding and regulatory changes.

As our government funded businesses grow, our exposure to changes in federal and state government policy with respect to and/or regulation of the various government funded programs in which we participate also increases.

The laws and regulations governing participation in Medicare Advantage (including dual eligible special needs plans), Medicare Part D, Medicaid, and Managed Medicaid plans are complex, are subject to interpretation and can expose us to penalties for non-compliance. Federal, state and local governments have the right to cancel or not to renew their contracts with us on short notice without cause or if funds are not available. Funding for these programs is dependent on many factors outside

our control, including general economic conditions, continuing government efforts to contain health care costs and budgetary constraints at the federal or applicable state or local level and general political issues and priorities.

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

Possible changes in industry pricing benchmarks and drug pricing generally can adversely affect our PBM and Pharmacy & Consumer Wellness businesses.

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

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

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

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

Since 2013, HHS has issued determinations to health plans that their premium rate increases were "unreasonable," and we may experience challenges to appropriate premium rate increases in certain states. Regulators or legislatures in several states have implemented or are considering limits on premium rate increases, either by enforcing existing legal requirements more stringently or proposing different regulatory standards. Regulators or legislatures in several states also have conducted hearings on proposed premium rate increases, which can result, and in some instances have resulted, in substantial delays in implementing proposed rate increases even if they ultimately are approved. Any significant rate increases we may request heighten the risks of adverse publicity, adverse regulatory action and adverse selection and the likelihood that our requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

We anticipate continued regulatory and legislative action to increase regulation of premium rates in our Insured Health Care Benefits products. We may not be able to obtain rates that are actuarially justified or that are sufficient to make our policies

profitable in one or more product lines or geographies. If we are unable to obtain adequate premium rates and/or premium rate increases, it could materially and adversely affect our operating margins and MBRs and our ability to earn adequate returns on Insured Health Care Benefits products in one or more states or cause us to withdraw from certain geographies and/or products.

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

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

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

Congress and certain state legislatures continue to consider and pass legislation that increases our costs of doing business, including increased minimum wages and requiring employers to provide paid sick leave or paid family leave. In addition, our employee-related operating costs may be increased by the proposed changes to the H-1B and other visa programs, which could limit our and others' ability to hire skilled individuals. Regarding union organizing activity, it is possible that the National Labor Relations Board may adopt regulatory changes through re-making or case law that could facilitate union organizing. If we are unable to reflect these increased expenses in our pricing or otherwise modify our operations to mitigate the effects of such increases, our operating results will be adversely affected.

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

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

Our international operations increase our exposure to, and require us to devote significant management resources to implement controls and systems to comply with, the privacy and data protection laws of non-U.S. jurisdictions, such as the EU's GDPR, and the anti-bribery, anti-corruption and anti-money laundering laws of the U.S. (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 may also require the investment of considerable management time and financial and other resources. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or employees, restrictions or outright prohibitions on the conduct of our business, and significant brand and reputational harm. We must regularly reassess the size, capability and location of our global infrastructure and make appropriate changes, and must have effective change management processes and internal controls in place to address changes in our businesses and operations. Our success depends, in part, on our ability to anticipate these risks and manage these difficulties, and the failure to do so could have a material adverse effect on our brand, reputation, businesses, operating results and/or financial condition.

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

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

Risks Related to Our Operations

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

Our ability to attract and retain customers and members is dependent upon providing compliant, cost effective, quality customer service operations (such as call center operations, PBM functions, retail pharmacy, retail, mail order and specialty pharmacy prescription delivery, claims processing, customer case installation and online access and tools) that meet or exceed our customers' and members' expectations, either directly or through vendors. We depend on third parties for certain of our customer service, PBM and prescription delivery operations. If we or our vendors fail to provide compliant service that meets our customers' and members' expectations, we may have difficulty retaining or profitably growing our customer base and/or membership, which could adversely affect our operating results.

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

We and our vendors have experienced diverse cyberattacks and expect to continue to experience cyberattacks going forward. As examples, the Company and its vendors have experienced attempts to gain access to systems, denial of service attacks, attempted malware infections, account takeovers, scanning activity, and phishing emails. We have also seen an increase in ransomware attacks in our industry. Attacks can originate from external sources (including criminals, terrorists and nation states) or internal actors. The Company is dedicating and will continue to dedicate significant resources and incur significant expenses to maintain and update on an ongoing basis the systems and processes that are designed to mitigate the information security risks it faces and protect the security of its computer systems, software, networks and other technology assets against attempts by unauthorized parties to obtain access to confidential information, disrupt or degrade service, or cause other damage. The impact of known cyberattacks has not been material to the Company's operations or operating results through December 31, 2025. The Board is regularly informed regarding the Company's information security policies, practices and status.

A compromise of our information security controls or of those third parties with whom we interact, which results in business disruption or confidential information being accessed, obtained, damaged, or used by unauthorized or improper persons, could harm our reputation and expose us to regulatory actions and claims from customers and clients, financial institutions, payment card associations and other persons, any of which could adversely affect our businesses, operating results and financial condition. Because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may not immediately produce signs of intrusion, we may be unable to anticipate these techniques or to implement adequate preventative measures. Moreover, a cyberattack 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 cyberattack or other information security incident are significant. Following an information security incident, our and/or our vendors' remediation efforts may not be successful, and could result in interruptions, delays or cessation of service, and loss of existing or potential customers and members. In addition, breaches of our and/or our vendors' security measures and the unauthorized access to or dissemination of personal information, proprietary information or confidential information about us, our customers, our

members or other third parties, could expose our customers', members' and other constituents' information and our customers, members and other constituents to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, and result in investigations, regulatory enforcement actions, material fines and penalties, loss of customers, litigation or other actions, which could have a material adverse effect on our brand, reputation, businesses, operating results and cash flows.

See Item 1C of this 10-K, "Cybersecurity," for more information on the Company's cybersecurity risk management and governance.

Data governance failures can adversely affect our reputation, businesses and prospects. Our use and disclosure of members', customers' and other constituents' personal information is subject to complex regulations at multiple levels.

Our information systems are critical to the operation of our businesses. We collect, process, maintain, retain, evaluate, utilize and distribute large amounts of personally identifiable, protected health, and financial information (including payment card information) and other confidential and sensitive data about our customers, employees, members and other constituents in the ordinary course of our businesses. Some of our information systems rely upon third party systems, including cloud service providers, to accomplish these tasks. The use and disclosure of such information is regulated at the federal, state and international levels. 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. These laws, rules and regulations are subject to change (and many are rapidly evolving) and in recent years have given rise to increased enforcement activity, litigation, and other disputes. For example, certain of our vendors have experienced incidents that resulted in the unauthorized disclosure of confidential information, including personal information of our members, patients or employees, which has caused us to incur expenses including those related to responding to regulatory inquiries and/or litigation. Some of these expenses are indemnified but others are not. International laws, rules and regulations governing the use and disclosure of these types of information are generally more stringent than U.S. laws and regulations, and they vary from jurisdiction to jurisdiction. Our businesses also depend on our customers', members' and other constituents' willingness to entrust us with their health related and other personal information. Events that adversely affect that trust, noncompliance with applicable privacy or security laws or regulations, or any security breach, information security incident, and any other incident involving the theft, misappropriation, compromise, loss or other unauthorized disclosure of, or access to, customer, member or other constituent information, whether by us, by one of our business associates or vendors or by another third party, could require us to expend significant resources to remediate any damage, could interrupt our operations and could adversely affect our brand and reputation, membership and operating results and also could expose and/or has exposed us to mandatory disclosure requirements, adverse media attention, litigation (including class action litigation), governmental investigations and enforcement proceedings, material fines, penalties and/or remediation costs, and compensatory, special, punitive and statutory damages, consent orders, adverse actions against our licenses to do business and/or injunctive relief, any of which could adversely affect our businesses, operating results, cash flows or financial condition.

There can be no assurance that we have been able to, or will be able to, adequately prevent, detect, and/or remediate such data security incidents.

Our business success and operating results depend in part on effective information technology systems and on continuing to develop and implement improvements in technology, including technology related to artificial intelligence ("AI"). The failure or disruption of our information technology systems or the failure of our information technology infrastructure to support our businesses could adversely affect our reputation, businesses, operating results and cash flows.

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 information and technology systems to manage our ordering, pricing, point-of-sale, pharmacy fulfillment, inventory replenishment, claims processing, customer loyalty and subscription programs, finance, human resources and other processes. Throughout our operations, we collect, process, maintain, retain, evaluate, utilize and distribute large amounts of confidential and sensitive data and information, including personally identifiable information and protected health information, that our customers, employees, members and other constituents provide to purchase products or services, enroll in programs or services, register on our websites, interact with our personnel, or otherwise communicate with us. 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 different businesses, including technology acquired as part of acquisitions. Our businesses depend in large part on these systems to adequately price our products and services; accurately establish reserves, process claims and report operating results; and interact with providers, employer plan sponsors, customers, members, consumers and vendors in an efficient and uninterrupted fashion. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated

applications for mobile devices. We must continuously develop and acquire new technology systems, contract with new vendors or modify certain of our existing systems to support the consumer-oriented and transformational 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, emerging cybersecurity risks and threats, and changes to applicable privacy and security laws, rules and regulations. If we fail to achieve these objectives, our ability to profitably grow our business and/or our operating results may be adversely affected.

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

Our and our vendors' 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), cyberattacks, vandalism, catastrophic events and human error. If our information systems are damaged, fail to work properly or otherwise become unavailable, we may incur substantial costs to repair or replace them, and may experience reputational damage, loss of critical information, customer disruption and interruptions or delays in our ability to perform essential functions and implement new and innovative services.

The use of AI and related technology may also increase exposure to reputational, cybersecurity, data privacy, legal, regulatory and operational risks as AI technology rapidly evolves along with public opinion concerning the use of AI and the associated legal and regulatory framework. These risks include, but are not limited to, heightened exposure to cybersecurity incidents or the misuse of data during the integration of AI models and large data sets; increased potential liability and costs associated with complying with rapidly emerging regulatory frameworks; costs and competitive disadvantages associated with the failure to properly integrate AI into existing operations; and reputational harm caused by actual or perceived failures in the performance of AI or AI-related technology.

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

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

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

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

In addition, our failure to adequately plan for succession of senior management and other key management roles or the failure of key employees to successfully transition into new roles could have a material adverse effect on our businesses, operating

results and/or future performance. The succession plans we have in place and our employment arrangements with certain key executives do not guarantee the services of these executives will continue to be available to us.

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

Our products are sold primarily through our sales personnel, who frequently work with independent brokers, consultants and agents who assist in the marketing, production and servicing of business. The independent brokers, consultants and agents generally are not exclusively dedicated to us and may frequently recommend and/or market health care benefits products of our competitors. 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.

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

In addition, there have been several investigations regarding the marketing practices of brokers and agents selling health care and other insurance products and the payments they receive from carriers offering Medicare Advantage, Medicare Part D and Medicare Supplemental Insurance products. These investigations have resulted in enforcement actions against companies in our industry and brokers and agents marketing and selling those companies' products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans and/or changes to industry practices, which could adversely affect our ability to market our products.

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

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

We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to new rules and other requirements and potential liability and may 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 that may subject us to new and additional risks related to fraud and theft. 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 and regulatory requirements governing these payment methods. 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 we currently use or adopt in the future. If these vendors are unable to provide these services to us, or if their systems are compromised, our operations could be disrupted. The payment methods that we offer also expose us to potential fraud and theft by persons seeking to obtain unauthorized access to, or exploit any weaknesses in, the payment systems we use. If we fail to abide by applicable rules or requirements, or if data relating to our payment systems is compromised due to a breach or misuse, we may be responsible for any costs incurred by payment card issuing banks and other third parties or subject to fines and higher transaction fees. In addition, our reputation and ability to accept certain types of payments could each be harmed resulting in reduced sales and adverse effects on our operating results.

Financial Risks

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

Our operations generate significant capital, and we may from time to time raise additional capital, subject to market conditions. The manner in which we deploy our capital, including investments in our businesses, our operations (such as information technology and other strategic and capital projects), dividends, acquisitions, share and/or debt repurchases, repayment of debt, reinsurance or other capital uses, impacts our financial strength, claims paying ability and credit ratings issued by nationally-recognized statistical rating organizations. Credit ratings issued by nationally-recognized statistical rating organizations are broadly distributed and generally used throughout our industries. Our ratings reflect each rating organization's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to our insureds. We believe our credit ratings and the financial strength and claims paying ability of our principal insurance and HMO subsidiaries are important factors in marketing our Health Care Benefits products to certain of our customers.

The Company's long-term debt ratings are currently investment grade, though 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. As of December 31, 2025, Moody's Investor Service, Inc. has assigned the Company a long-term debt rating of "Baa3" and a commercial paper rating of "P-3" with a "Stable" outlook; Standard & Poor's Financial Services LLC has assigned the Company a long-term debt rating of "BBB" and a commercial paper rating of "A-2" with a "Negative" outlook; and Fitch Ratings, Inc. has assigned the Company a long-term debt rating of "BBB" and a commercial paper rating of "F2" with a "Negative" outlook. Downgrades in our ratings could adversely affect our businesses, operating results, cash flows and financial condition.

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

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

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

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

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

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

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

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

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

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

Much of the branded and generic drug product that we sell in our pharmacies, and much of the other merchandise we sell, is manufactured in whole or in substantial part outside of the U.S. 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 U.S. and other countries, such as the imposition of unilateral tariffs on imported products, could result in significant increases in our costs, restrict our access to suppliers, depress economic activity, and have a material adverse effect on our businesses, operating results and cash flows. The current administration has imposed and may further impose, or significantly increase, tariffs on imports to the United States, which could exacerbate many of these issues. In addition, other countries may change their business and trade policies and such changes, as well as any negative sentiments towards the U.S. in response to increased import tariffs and other changes in U.S. trade regulations, including those that are imposed or threatened by the new administration, could adversely affect our businesses.

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

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

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

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

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

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

Item 1B. Unresolved Staff Comments.

There are no unresolved SEC Staff Comments.

Item 1C. Cybersecurity.

Cybersecurity Risk Management

Cybersecurity is an important and integrated part of the Company's enterprise risk management strategy. Safeguarding the Company's business information, intellectual property, customer, patient and employee data and technology systems is essential for the continuity of its businesses, meeting applicable regulatory requirements and maintaining the trust of its stakeholders.

To help protect the Company from a major cybersecurity incident that could have a material impact on operations or the Company's financial results, the Company has implemented a robust information security program and has made technology investments that focus on cybersecurity incident prevention, detection and mitigation. The steps the Company takes to reduce its vulnerability and to mitigate the impacts from cybersecurity incidents include, but are not limited to: comprehensive information security policies and standards, implementing logical and technical controls through processes and technologies, monitoring its information technology systems for cybersecurity threats, assessing cybersecurity risk profiles of key third

parties, implementing cybersecurity training and collaborating with public and private organizations on cyber threat information and best practices. The Company is currently in material compliance with applicable information privacy and cybersecurity standards.

The Company has implemented a Cybersecurity Incident Response Plan (the "Plan"), which is integrated into its overall crisis management program. The Plan provides a framework for responding to cybersecurity incidents. The Plan identifies applicable requirements for incident disclosure and reporting as well as provides protocols for incident evaluation, including the use of third-party service providers and partners, processes for notification and internal escalation of information to the Company's senior management, the disclosure committee, the Board and appropriate Board committees. The Plan also addresses requirements for the Company's external reporting obligations. The Plan is reviewed and updated, as necessary, under the leadership of the Company's Chief Information Security Officer ("CISO") and Chief Privacy Officer ("CPO").

The Company's information technology systems and processes are regularly assessed internally as well as by independent third parties for compliance with the following standards: HIPAA; NIST 800-53; System and Organization Controls ("SOC") 1; SOC 2 Type 2; HI-TRUST; Payment Card Industry Data Security Standards; and the National Association of Insurance Commissioners. The Company annually purchases a cybersecurity risk insurance policy that is expected to help defray the costs associated with a covered cybersecurity incident if it occurred.

Although the Company did not experience a material cybersecurity incident during the year ended December 31, 2025, the scope and impact of any future direct or third-party cybersecurity incident cannot be predicted. See "Item 1A. Risk Factors" for more information on the Company's cybersecurity-related risks.

Governance

Management has responsibility to manage risk and bring to the Board's attention the most material near-term and long-term risks to the Company. The Company's CISO leads management's assessment and management of cybersecurity risk. The CISO reports to the Company's Chief Experience and Technology Officer (the "CETO"), who reports directly to the Company's Chief Executive Officer. The CETO, CISO and the CPO, regularly review cybersecurity matters with management. The current CETO, CISO and CPO each has more than 10 years of experience managing risks or advising on cybersecurity issues.

The Board is actively engaged in overseeing and reviewing the Company's strategic direction and objectives, taking into account, among other considerations, the Company's risk profile and related exposures. As part of this oversight, the Board has delegated certain of these responsibilities to committees of the Board. The Board has delegated the responsibility for the oversight of the Company's cybersecurity risks to the Audit Committee. As part of its risk oversight responsibilities, the Audit Committee conducts regular reviews of the Company's cybersecurity program, including no fewer than two formal updates each year. The Company's CETO and CISO provide the Audit Committee with recurring briefings—at least on a bi-quarterly basis—and update the full Board annually on the Company's cybersecurity posture. These updates include assessments of emerging cyber threats, significant cybersecurity incidents and material changes in the Company's risk profile. The CISO is a member of the Company's Disclosure Committee, and the CPO advises the Disclosure Committee on cybersecurity matters on an as-needed basis.

Item 2. Properties.

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

Health Care Benefits Segment

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

Health Services Segment

The Health Services segment includes owned or leased mail service dispensing pharmacies, call centers, on-site pharmacy stores, retail specialty pharmacy stores, specialty mail service pharmacies and primary care centers.

The Health Services segment leases 246 primary care centers across 27 states, totaling approximately 2.2 million square feet.

The Health Services segment also owns or leases office space used for administration, sales and marketing, technology and development and professional services throughout the U.S. and in Ireland.

Pharmacy & Consumer Wellness Segment

As of December 31, 2025, the Pharmacy & Consumer Wellness segment operated the following properties:

- More than 7,000 retail stores, of which approximately 4% were owned. Net selling space for retail stores was approximately 71.3 million square feet as of December 31, 2025.
- Approximately 1,870 retail pharmacies within retail chains, as well as approximately 30 clinics in Target Corporation (“Target”) stores;
- Owned distribution centers and leased distribution facilities throughout the U.S. totaling approximately 10.0 million square feet; and
- Branches for compounding, specialty infusion and enteral nutrition services throughout the U.S.

In connection with certain business dispositions completed between 1995 and 1997, the Company continues to guarantee lease obligations for 60 former stores. The Company is indemnified for these guarantee obligations by the respective initial purchasers. These guarantees generally remain in effect for the initial lease term and any extension thereof pursuant to a renewal option provided for in the lease prior to the time of the disposition. For additional information on these guarantees, see “Lease Guarantees” in Note 18 ‘‘Commitments and Contingencies’’ included in Item 8 of this 10-K.

Management believes that the Company’s owned and leased facilities are suitable and adequate to meet the Company’s anticipated needs. At the end of the existing lease terms, management believes the leases can be renewed or replaced by alternative space. For additional information on the right-of-use assets and lease liabilities associated with the Company’s leases, see Note 7 ‘‘Leases’’ included in Item 8 of this 10-K.

Item 3. Legal Proceedings.

The information contained in Note 18 ‘‘Commitments and Contingencies’’ included in Item 8 of this 10-K is incorporated herein by reference.

Item 4. Mine Safety Disclosures.

Not applicable.

Information about our Executive Officers

The following sets forth the name, age and biographical information for each of the Registrant's executive officers as of February 10, 2026. In each case the officer's term of office extends to the date of the meeting of the Board following the next annual meeting of stockholders of CVS Health Corporation. Previous positions and responsibilities held by each of the executive officers over the past five years or more are indicated below:

Heidi B. Capozzi, age 56, has been the Executive Vice President and Chief People Officer of CVS Health Corporation since September 2024. Prior to joining the Company, Ms. Capozzi was most recently the Executive Vice President and Global Chief People Officer of McDonald's Corporation from April 2020 through August 2024.

James D. Clark, age 61, has been the Senior Vice President, Controller and Chief Accounting Officer of CVS Health Corporation since November 2018. Prior to joining the Company, Mr. Clark was a partner at Deloitte & Touche LLP, an independent registered public accounting firm.

Amy Compton-Philips, age 62, has been the Executive Vice President and Chief Medical Officer of CVS Health Corporation since May 2025. Prior to joining the Company, Dr. Compton-Philips was most recently the Chief Physician Executive of Press Ganey, a health care company known for developing and distributing patient satisfaction surveys, from September 2022 to April 2025 and the Chief Clinical Officer of Providence Health System, responsible for clinical operation, quality, pharmacy and clinical institutes from August 2015 to September 2022.

J. David Joyner, age 61, has been the President and Chief Executive Officer of CVS Health Corporation since October 2024, and Chair of the Board of Directors of CVS Health Corporation since January 2026. Prior to his current role with the Company, Mr. Joyner was most recently the Executive Vice President of CVS Health Corporation and President of Pharmacy Services from January 2023 through October 2024; Strategic Business Advisor to gWell, Inc., a wellness technology company, from July 2021 through September 2023; and Advisor to Podimetrics Inc., a health care company focused on the identification and treatment of diabetic foot ulcers from September 2020 through January 2023. Mr. Joyner has also served on the Advisory Council to the Rawls College of Business of Texas Tech University since July 2020.

Samrat S. Khichi, age 58, has been the Executive Vice President, Chief Policy Officer and General Counsel of CVS Health Corporation since February 2023. Prior to joining the Company, Mr. Khichi was most recently the Executive Vice President, Corporate Development, Public Policy, Regulatory Affairs and General Counsel of Becton Dickinson Company, a global medical technology company, from December 2017 through February 2023.

Tilak Mandadi, age 62, has been the Executive Vice President, Ventures and Chief Experience and Technology Officer of CVS Health Corporation, or held the same role with a different title, since July 2022. Prior to joining the Company, Mr. Mandadi was most recently the Chief Strategy Officer of MGM Resorts International from July 2021 through July 2022 and the Executive Vice President, Digital & Global Chief Technology Officer of Disney Parks, Experiences and Products, a division of The Walt Disney Company, from March 2013 through July 2021.

Steven H. Nelson, age 67, has been the Executive Vice President and President, Aetna of CVS Health Corporation since November 2024. Prior to joining the Company, Mr. Nelson was most recently the Chief Executive Officer of ChenMed LLC ("ChenMed"), a health care provider focused on senior citizens, from February 2024 through August 2024; President of ChenMed, from August 2023 through January 2024; President of JenCare Senior Medical Center, a ChenMed company, from September 2022 through August 2023; and Co-Chairman and Chief Executive Officer of Duly Health and Care, a large multispecialty independent provider group, from July 2020 through September 2022.

Brian O. Newman, age 57, has been the Executive Vice President and Chief Financial Officer of CVS Health Corporation since May 2025. Prior to joining the Company, Mr. Newman was most recently the Executive Vice President and Chief Financial Officer of United Parcel Service, Inc. from September 2019 through May 2024.

Prem S. Shah, age 46, has been the Executive Vice President and Group President of CVS Health Corporation since November 2024. Prior to his current role with the Company, Mr. Shah was most recently the Executive Vice President and Chief Pharmacy Officer of CVS Health Corporation from November 2021 through November 2024 and President or Co-President of Retail from January 2022 through November 2024. Mr. Shah was the Executive Vice President, Specialty and Product Innovation, CVS Caremark from August 2018 through November 2021.

PART II

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

Market Information

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

Dividends

The quarterly cash dividend was $0.665 per share in 2025 and 2024 and $0.605 per share in 2023. CVS Health Corporation has paid cash dividends every quarter since becoming a public company and expects to maintain its quarterly dividend of $0.665 per share throughout 2026. Future dividends will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

See Note 14 ''Shareholders' Equity'' included in Item 8 of this 10-K for information regarding CVS Health Corporation's dividends.

Holders of Common Stock

As of February 4, 2026, there were 20,648 registered holders of the registrant's common stock according to the records maintained by the registrant's transfer agent.

Issuer Purchases of Equity Securities

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

In billions **Authorization Date**	**Authorized**	**Remaining as of December 31, 2025**
November 17, 2022 ("2022 Repurchase Program")	$ 10.0	$ 10.0
December 9, 2021 ("2021 Repurchase Program")	10.0	1.5

Each of the share Repurchase Programs was effective immediately and 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. Both the 2022 and 2021 Repurchase Programs can be modified or terminated by the Board at any time.

During the year ended December 31, 2025, the Company did not repurchase any shares of its common stock. During the years ended December 31, 2024 and 2023, the Company repurchased an aggregate of 39.7 million shares of common stock for approximately $3.0 billion and an aggregate of 22.8 million shares of common stock for approximately $2.0 billion, respectively, each pursuant to the 2021 Repurchase Program. This activity includes the share repurchases under the ASR transactions described below.

Pursuant to the authorization under the 2021 Repurchase Program, the Company entered into a $3.0 billion fixed dollar ASR with Morgan Stanley & Co. LLC. Upon payment of the $3.0 billion purchase price on January 4, 2024, the Company received a number of shares of CVS Health Corporation's common stock equal to 85% of the $3.0 billion notional amount of the ASR or approximately 31.4 million shares, which were placed into treasury stock in January 2024. The ASR was accounted for as an initial treasury stock transaction for $2.6 billion and a forward contract for $0.4 billion. The forward contract was classified as an equity instrument and was recorded within capital surplus. In March 2024, the Company received approximately 8.3 million shares of CVS Health Corporation's common stock, representing the remaining 15% of the $3.0 billion notional amount of the ASR, thereby concluding the ASR. These shares were placed into treasury and the forward contract was reclassified from capital surplus to treasury stock in March 2024.

Pursuant to the authorization under the 2021 Repurchase Program, the Company entered into a $2.0 billion fixed dollar ASR with Citibank, N.A. Upon payment of the $2.0 billion purchase price on January 4, 2023, the Company received a number of shares of CVS Health Corporation's common stock equal to 80% of the $2.0 billion notional amount of the ASR or approximately 17.4 million shares, which were placed into treasury stock in January 2023. The ASR was accounted for as an

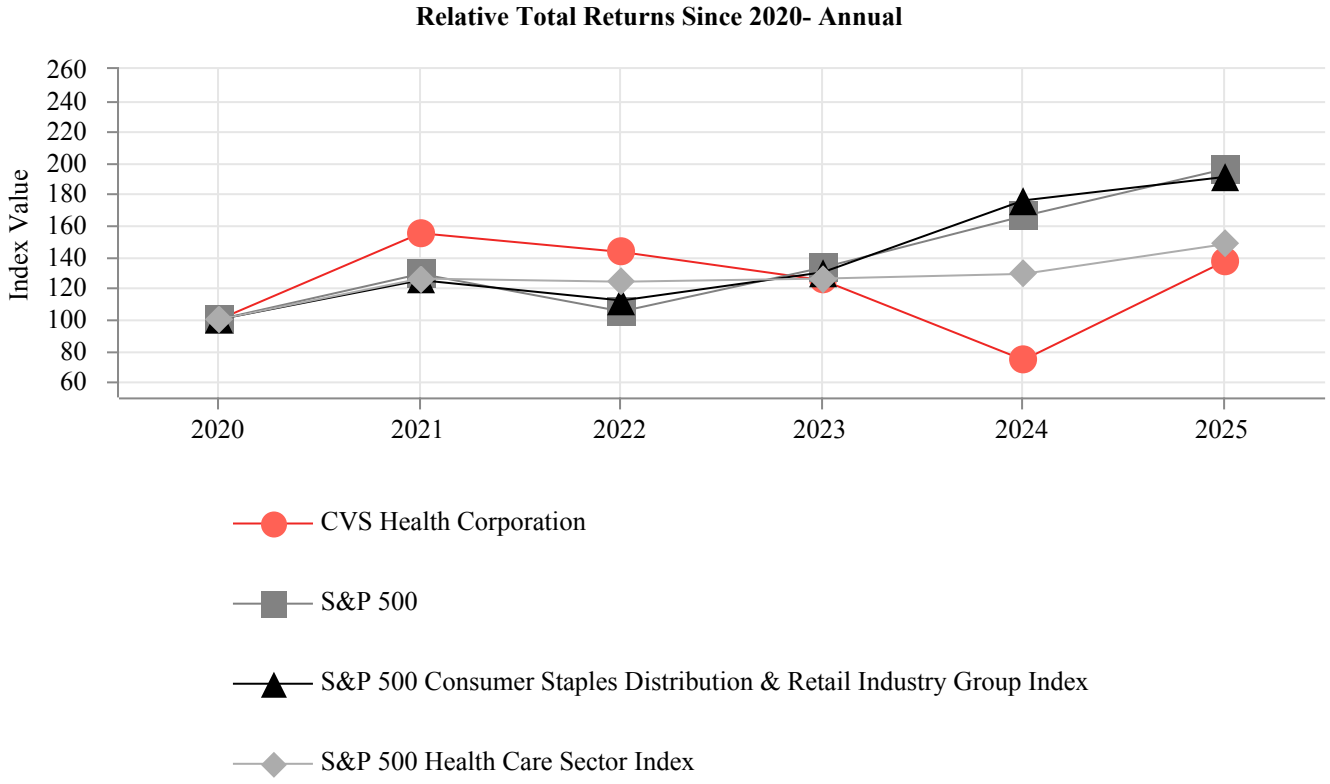
initial treasury stock transaction for $1.6 billion and a forward contract for $0.4 billion. The forward contract was classified as an equity instrument and was recorded within capital surplus. In February 2023, the Company received approximately 5.4 million shares of CVS Health Corporation's common stock, representing the remaining 20% of the $2.0 billion notional amount of the ASR, thereby concluding the ASR. These shares were placed into treasury stock and the forward contract was reclassified from capital surplus to treasury stock in February 2023.

At the time they were received, the initial and final receipt of shares resulted in an immediate reduction of the outstanding shares used to calculate the weighted average common shares outstanding for basic and diluted earnings per share.

See Note 14 ''Shareholders' Equity'' included in Item 8 of this 10-K for additional information regarding the Company's share repurchases.

Stock Performance Graph

The following graph compares the cumulative total shareholder return on CVS Health Corporation's common stock (assuming reinvestment of dividends) with the cumulative total return on the S&P 500 Index, the S&P 500 Consumer Staples Distribution & Retail Industry Group Index and the S&P 500 Health Care Sector Index from December 31, 2020 through December 31, 2025. The graph assumes a $100 investment in shares of CVS Health Corporation's common stock on December 31, 2020.



	December 31,					
	2020	2021	2022	2023	2024	2025
CVS Health Corporation	$ 100	$ 155	$ 143	$ 125	$ 74	$ 137
S&P 500 [1]	100	129	105	133	166	196
S&P 500 Consumer Staples Distribution & Retail Industry Group Index [2]	100	125	112	130	176	191
S&P 500 Health Care Sector Index [1] [3]	100	126	124	126	129	148

(1) Includes CVS Health Corporation.
(2) Includes 7 companies (COST, DG, DLTR, KR, SYY, TGT, WMT).
(3) Includes 60 companies.

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

Item 6. Reserved

Not applicable.

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

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

Overview of Business

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is a 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, 2025, the Company had approximately 9,000 retail locations, more than 1,000 walk-in and primary care medical clinics and a leading pharmacy benefits manager with approximately 87 million plan members and expanding specialty pharmacy solutions. The Company also serves an estimated more than 37 million people through traditional, voluntary and consumer-directed health insurance products and related services, including expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). The Company is creating new sources of value through its integrated model allowing it 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.

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

Overview of the Health Care Benefits Segment

The Health Care Benefits segment operates as one of the nation's leading diversified health care benefits providers through its Aetna® operations. 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 primary customers, its members, primarily access the segment's products and services through employer groups, government-sponsored plans or individually. The Health Care Benefits segment also serves customers who purchase products and services that are ancillary to its health insurance products. The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk for medical and dental care costs) as "ASC." The Company also sold Insured plans directly to individual consumers through the individual public health insurance exchanges ("Public Exchanges") through the year ended December 31, 2025. The Company exited the states in which Aetna operated on the Public Exchanges effective January 2026.

Overview of the Health Services Segment

The Health Services segment provides a full range of pharmacy benefit management ("PBM") solutions through its CVS Caremark® operations and delivers health care services in its medical clinics, virtually, and in the home. 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. The segment also works directly with pharmaceutical manufacturers to commercialize and/or co-produce high quality biosimilar products through its Cordavis™ subsidiary. The Health Services segment's health care delivery assets include Signify Health, Inc. ("Signify Health"), a leader in health risk assessments and value-based care, and Oak Street Health, Inc. ("Oak Street Health"), a leading multi-payor operator of value-based primary care centers serving Medicare eligible patients. The Health Services segment's clients and customers are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Medicaid managed care plans, the U.S. Centers for Medicare & Medicaid Services ("CMS"), plans offered on public and private health 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.

Overview of the Pharmacy & Consumer Wellness Segment

The Pharmacy & Consumer Wellness segment dispenses prescriptions in its CVS Pharmacy® retail locations and through its infusion operations, provides ancillary pharmacy services including pharmacy patient care programs and vaccination administration, and sells a wide assortment of health and wellness products and general merchandise. The segment also provides pharmacy fulfillment services to support the Health Services segment's specialty and mail order pharmacy offerings. As of December 31, 2025, the Pharmacy & Consumer Wellness segment operated approximately 9,000 retail locations, as well as online retail pharmacy websites, retail specialty pharmacy stores, compounding pharmacies and branches for infusion and enteral nutrition services.

Overview of the Corporate/Other Segment

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

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

Results of Operations

The following information summarizes the Company's results of operations for 2025 compared to 2024.

For discussion of the Company's results of operations for 2024 compared to 2023, see "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2024 filed with the U.S. Securities and Exchange Commission (the "SEC") on February 12, 2025.

Summary of Consolidated Financial Results

	Year Ended December 31,			Change			
				2025 vs. 2024		2024 vs. 2023	
In millions	**2025**	**2024**	**2023**	**$**	**%**	**$**	**%**
Revenues:							
Products	$249,908	$231,521	$245,138	$ 18,387	7.9 %	$ (13,617)	(5.6)%
Premiums	134,751	122,896	99,192	11,855	9.6 %	23,704	23.9 %
Services	15,175	16,239	12,293	(1,064)	(6.6)%	3,946	32.1 %
Net investment income	2,233	2,153	1,153	80	3.7 %	1,000	86.7 %
Total revenues	402,067	372,809	357,776	29,258	7.8 %	15,033	4.2 %
Operating costs:							
Cost of products sold	221,167	206,287	217,098	14,880	7.2 %	(10,811)	(5.0)%
Health care costs	125,538	115,121	86,247	10,417	9.0 %	28,874	33.5 %
Operating expenses	44,977	41,706	39,832	3,271	7.8 %	1,874	4.7 %
Goodwill impairment	5,725	—	—	5,725	100.0 %	—	— %
Restructuring charges	—	1,179	507	(1,179)	(100.0)%	672	132.5 %
Loss on assets held for sale	—	—	349	—	— %	(349)	(100.0)%
Total operating costs	397,407	364,293	344,033	33,114	9.1 %	20,260	5.9 %
Operating income	4,660	8,516	13,743	(3,856)	(45.3)%	(5,227)	(38.0)%
Interest expense	(3,119)	(2,958)	(2,658)	(161)	(5.4)%	(300)	(11.3)%
Gain on early extinguishment of debt	—	491	—	(491)	(100.0)%	491	100.0 %
Gain on deconsolidation of subsidiary	483	—	—	483	100.0 %	—	— %
Other income	112	99	88	13	13.1 %	11	12.5 %
Income before income tax provision	2,136	6,148	11,173	(4,012)	(65.3)%	(5,025)	(45.0)%
Income tax provision	408	1,562	2,805	(1,154)	(73.9)%	(1,243)	(44.3)%
Net income	1,728	4,586	8,368	(2,858)	(62.3)%	(3,782)	(45.2)%
Net (income) loss attributable to noncontrolling interests	40	28	(24)	12	42.9 %	52	216.7 %
Net income attributable to CVS Health	$ 1,768	$ 4,614	$ 8,344	$ (2,846)	(61.7)%	$ (3,730)	(44.7)%

Commentary - 2025 compared to 2024

Revenues

- Total revenues increased $29.3 billion, or 7.8%, in 2025 compared to 2024. The increase in total revenues was driven by growth across all operating segments.
- Please see "Segment Analysis" later in this MD&A for additional information about the revenues of the Company's segments.

Operating expenses

- Operating expenses increased $3.3 billion, or 7.8%, in 2025 compared to 2024. The increase in operating expenses was primarily due to approximately $1.2 billion of legacy litigation charges related to two court decisions associated with the Company's past business practices, a $320 million opioid litigation charge related to a change in the Company's accrual for ongoing opioid litigation matters and $288 million of pre-tax losses on Accountable Care assets, all recorded in 2025, as well as increased investments in colleagues and capabilities in 2025.

- Please see “Segment Analysis” later in this MD&A for additional information about the operating expenses of the Company’s segments.

Operating income
- Operating income decreased $3.9 billion, or 45.3%, in 2025 compared to 2024. The decrease in operating income was primarily due to a $5.7 billion goodwill impairment charge related to the Health Care Delivery reporting unit and the $1.2 billion of legacy litigation charges described above, both recorded during the year ended December 31, 2025. These decreases were partially offset by improved operating performance in the Health Care Benefits segment and the absence of approximately $1.2 billion of restructuring charges recorded in the prior year.
- Please see “Segment Analysis” later in this MD&A for additional information about the operating results of the Company’s segments.

Interest expense
- Interest expense increased $161 million, or 5.4%, in 2025 compared to 2024 primarily as a result of long-term debt issuances in December 2024 and August 2025. See “Liquidity and Capital Resources” later in this MD&A for additional information.

Gain on early extinguishment of debt
- During 2024, the gain on early extinguishment of debt relates to the Company’s repayment of $2.6 billion of its outstanding senior notes pursuant to its tender offers for such senior notes in December 2024, which resulted in a gain on early extinguishment of debt of $491 million. See Note 10 ‘‘Borrowings and Credit Agreements’’ included in Item 8 of this 10-K for additional information.

Gain on deconsolidation of subsidiary
- During 2025, the gain on deconsolidation of subsidiary relates to Omnicare, LLC (“Omnicare”), a wholly-owned indirect subsidiary of CVS Health Corporation, and certain of its subsidiary entities (collectively, the “Omnicare Entities”). See Note 1 ‘‘Significant Accounting Policies’’ included in Item 8 of this 10-K for additional information on the deconsolidation of the Omnicare Entities.

Income tax provision
- The Company’s effective income tax rate decreased to 19.1% in 2025 compared to 25.4% in the prior year due to a worthless stock deduction associated with a subsidiary that filed for bankruptcy in 2025, partially offset by the impact of the goodwill impairment charge and the legacy litigation charges recorded during 2025 described above, both of which were not deductible for income tax purposes.

Trends and Uncertainties

The Company believes you should consider the following business and regulatory trends and uncertainties:

Business Trends and Uncertainties

- Utilization is expected to persist at elevated levels in 2026. Although the level of utilization is difficult to accurately predict, utilization beyond current elevated levels may pressure the Company's Health Care Benefits segment and its health care delivery assets in its Health Services segment in 2026.
- The Company continues to share with clients a larger portion of rebates, fees and/or discounts received from pharmaceutical manufacturers, and typically offers clients minimum pricing guarantees that cannot always be achieved. The Company also faces increasing pressure from pharmaceutical manufacturers with respect to the calculation and collection of rebates. 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." The Company expects these trends to continue.
- Changes in the economic environment, including inflation, the implementation of new tariffs or changes in tariffs, including the impact of tariffs on trade relations between the U.S. and foreign countries, and labor and other market dynamics could create exposure for increased costs and supply chain disruptions that can adversely impact consumer demand, the ability to deliver client savings or the Company's financial results.
- Consumer spend management and a decline in consumer discretionary spending, as well as a shift to value, grocery and digital retailers, could drive lower front store sales in the Pharmacy & Consumer Wellness segment.

Regulatory Trends and Uncertainties

- The Company is exposed to funding and regulation of, and changes in government policy with respect to and/or funding or regulation of, the various Medicare and Medicaid 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, including changes to applicable risk adjustment mechanisms.
- Legislation and/or regulations seeking to regulate PBM activities in a comprehensive manner have been proposed or enacted in a majority of states and on the federal level. This legislative and regulatory activity could adversely affect the Company's ability to conduct business on commercially reasonable terms and the Company's ability to standardize its PBM products and services across state lines.

For additional information regarding these and other trends and uncertainties, see Item 1A, "Risk Factors" and Part I, Item 1 "Business - Government Regulation."

Segment Analysis

The following discussion of segment operating results is presented based on the Company's reportable segments in accordance with the accounting guidance for segment reporting and is consistent with the segment disclosure in Note 19 ''Segment Reporting'' included in Item 8 of this 10-K.

The Company has four reportable segments: Health Care Benefits, Health Services, Pharmacy & Consumer Wellness and Corporate/Other. The Company's segments maintain separate financial information, and the Chief Operating Decision Maker (the "CODM") evaluates the segments' operating results on a regular basis in deciding how to allocate resources among the segments and in assessing segment performance. The Company's CODM is the Chief Executive Officer. The CODM evaluates the performance of the Company's segments based on adjusted operating income (loss). Adjusted operating income is defined as operating income (loss) as measured by accounting principles generally accepted in the United States of America ("GAAP") excluding the impact of amortization of intangible assets, net realized capital gains or losses and other items, if any, that neither relate to the ordinary course of the Company's business nor reflect the Company's underlying business performance. See the reconciliations of operating income (loss) (GAAP measure) to adjusted operating income (loss) below for further context regarding the items excluded from operating income in determining adjusted operating income. The CODM uses adjusted operating income as its principal measure of segment performance as it enhances the CODM's ability to compare past financial performance with current performance and analyze underlying business performance and trends. Non-GAAP financial measures the Company discloses, such as consolidated adjusted operating income, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

The following are reconciliations of financial measures of the Company's segments to the consolidated totals:

In millions	**Health Care Benefits**	**Health Services [1]**	**Pharmacy & Consumer Wellness**	**Corporate/ Other**	**Intersegment Eliminations [2]**	**Consolidated Totals**
2025						
Total revenues	$ 143,354	$ 190,425	$ 139,367	$ 484	$ (71,563)	$ 402,067
Adjusted operating income (loss)	2,939	7,151	6,040	(1,687)	—	14,443
2024						
Total revenues	$ 130,665	$ 173,605	$ 124,500	$ 451	$ (56,412)	$ 372,809
Adjusted operating income (loss)	307	7,243	5,774	(1,348)	—	11,976
2023						
Total revenues	$ 105,646	$ 186,843	$ 116,763	$ 451	$ (51,927)	$ 357,776
Adjusted operating income (loss)	5,577	7,312	5,963	(1,318)	—	17,534

(1) Total revenues of the Health Services segment include approximately $10.9 billion, $11.4 billion and $13.7 billion of retail co-payments for 2025, 2024 and 2023, respectively. See Note 1 ''Significant Accounting Policies'' included in Item 8 of this 10-K for additional information about retail co-payments.

(2) Intersegment revenue eliminations relate to intersegment revenue generating activities that occur between the Health Care Benefits segment, the Health Services segment, and/or the Pharmacy & Consumer Wellness segment.

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

	Year Ended December 31, 2025				
In millions	**Health Care Benefits**	**Health Services**	**Pharmacy & Consumer Wellness**	**Corporate/ Other**	**Consolidated Totals**
Operating income (loss) (GAAP measure)	$ 1,793	$ 220	$ 4,860	$ (2,213)	$ 4,660
Amortization of intangible assets [1]	1,155	569	249	3	1,976
Net realized capital (gains) losses [2]	(13)	(25)	—	82	44
Acquisition-related integration costs [3]	—	—	—	117	117
Goodwill impairment [4]	—	5,725	—	—	5,725
Health Care Delivery clinic closure charge [5]	—	83	—	—	83
Opioid litigation charge [6]	—	—	—	320	320
Office real estate optimization charges [7]	4	—	2	4	10
Legacy litigation charges [8]	—	291	929	—	1,220
Loss on Accountable Care assets [9]	—	288	—	—	288
Adjusted operating income (loss)	$ 2,939	$ 7,151	$ 6,040	$ (1,687)	$ 14,443

	Year Ended December 31, 2024				
In millions	**Health Care Benefits**	**Health Services**	**Pharmacy & Consumer Wellness**	**Corporate/ Other**	**Consolidated Totals**
Operating income (loss) (GAAP measure)	$ (984)	$ 6,937	$ 4,770	$ (2,207)	$ 8,516
Amortization of intangible assets [1]	1,175	595	253	2	2,025
Net realized capital (gains) losses [2]	97	(289)	—	75	(117)
Acquisition-related integration costs [3]	—	—	—	243	243
Opioid litigation charge [6]	—	—	—	100	100
Office real estate optimization charges [7]	19	—	4	7	30
Restructuring charges [10]	—	—	747	432	1,179
Adjusted operating income (loss)	$ 307	$ 7,243	$ 5,774	$ (1,348)	$ 11,976

	Year Ended December 31, 2023				
In millions	**Health Care Benefits**	**Health Services**	**Pharmacy & Consumer Wellness**	**Corporate/ Other**	**Consolidated Totals**
Operating income (loss) (GAAP measure)	$ 3,949	$ 6,842	$ 5,349	$ (2,397)	$ 13,743
Amortization of intangible assets [1]	1,177	465	260	3	1,905
Net realized capital losses [2]	402	—	5	90	497
Acquisition-related transaction and integration costs [3]	—	—	—	487	487
Office real estate optimization charges [7]	49	5	—	(8)	46
Restructuring charges [10]	—	—	—	507	507
Loss on assets held for sale [11]	—	—	349	—	349
Adjusted operating income (loss)	$ 5,577	$ 7,312	$ 5,963	$ (1,318)	$ 17,534

(1) The Company's acquisition activities have resulted in the recognition of intangible assets as required under the acquisition method of accounting which consist primarily of trademarks, customer contracts/relationships, covenants not to compete, technology, provider networks and value of business acquired. Definite-lived intangible assets are amortized over their estimated useful lives and are tested for impairment when events indicate that the carrying value may not be recoverable. The amortization of intangible assets is reflected in operating expenses within each segment. Although intangible assets contribute to the Company's revenue generation, the amortization of intangible assets does not directly relate to the underwriting of the Company's insurance products, the services performed for the Company's customers or the sale of the Company's products or services. Additionally, intangible asset amortization expense typically fluctuates based on the size and timing of the Company's acquisition activity. Accordingly, the Company believes excluding the amortization of intangible assets enhances the Company's and investors' ability to compare the Company's past financial performance with its current performance and to analyze underlying business performance and trends. Intangible asset amortization excluded from the related non-GAAP

financial measure represents the entire amount recorded within the Company's GAAP financial statements, and the revenue generated by the associated intangible assets has not been excluded from the related non-GAAP financial measure. Intangible asset amortization is excluded from the related non-GAAP financial measure because the amortization, unlike the related revenue, is not affected by operations of any particular period unless an intangible asset becomes impaired or the estimated useful life of an intangible asset is revised.

(2) The Company's net realized capital gains and losses arise from various types of transactions, primarily in the course of managing a portfolio of assets that support the payment of insurance liabilities. Net realized capital gains and losses are reflected in net investment income (loss) within each segment. These capital gains and losses are the result of investment decisions, market conditions and other economic developments that are unrelated to the performance of the Company's business, and the amount and timing of these capital gains and losses do not directly relate to the underwriting of the Company's insurance products, the services performed for the Company's customers or the sale of the Company's products or services. Accordingly, the Company believes excluding net realized capital gains and losses enhances the Company's and investors' ability to compare the Company's past financial performance with its current performance and to analyze underlying business performance and trends.

(3) In 2025 and 2024, the acquisition-related integration costs relate to the acquisitions of Signify Health and Oak Street Health. In 2023, the acquisition-related transaction and integration costs relate to the acquisitions of Signify Health and Oak Street Health. The acquisition-related transaction and integration costs are reflected in operating expenses within the Corporate/Other segment.

(4) In 2025, the goodwill impairment charge relates to the Health Care Delivery reporting unit within the Health Services segment.

(5) In 2025, the Health Care Delivery clinic closure charge primarily relates to the write down of long-lived assets in connection with the planned closure of certain existing Oak Street Health clinics in 2026, as well as associated severance and employee-related costs expected to be incurred. The Health Care Delivery clinic closure charge is reflected in operating expenses within the Health Services segment.

(6) In 2025 and 2024, the opioid litigation charges relate to changes in the Company's accrual related to ongoing opioid litigation matters.

(7) In 2025, 2024 and 2023, the office real estate optimization charges primarily relate to the abandonment of leased real estate and the related right-of-use assets and property and equipment in connection with the Company's evaluation of corporate office real estate space in response to its ongoing flexible work arrangement. The office real estate optimization charges are reflected in operating expenses within each segment.

(8) In 2025, the Company recorded legacy litigation charges related to two court decisions associated with its past business practices.

In April 2025, a jury found Omnicare and CVS Health Corporation liable in connection with alleged violations of the federal False Claims Act related to dispensing practices by Omnicare from 2010, prior to its acquisition by the Company in 2015, through 2018. Damages were found only with respect to Omnicare. Accordingly, the Company recorded a litigation charge of $387 million during the first quarter of 2025. During the second quarter of 2025, the Company recorded a charge of $542 million, reflecting penalties assessed under the False Claims Act. These litigation charges are reflected in operating expenses within the Pharmacy & Consumer Wellness segment.

In June 2025, a court found certain subsidiaries of CVS Health Corporation liable for damages in connection with a complaint filed in February 2014, in which the government declined to intervene, related to PBM direct and indirect remuneration reporting practices for two clients from 2010 through 2016, which the Company has since modified. In connection with this court decision, the Company recorded a litigation charge of $291 million during the second quarter of 2025. This litigation charge is reflected in operating expenses within the Health Services segment.

(9) In 2025, the loss on the wind down and sale of Accountable Care assets represents the pre-tax loss on the divestiture of the Company's Medicare Shared Savings Program ("MSSP") operations, which the Company sold in March 2025, as well as costs incurred in connection with the process of winding down the Company's Accountable Care Organization Realizing Equity, Access and Community Health ("ACO REACH") operations. The loss on Accountable Care assets is reflected in operating expenses within the Health Services segment.

(10) In 2024, the restructuring charges are primarily comprised of a store impairment charge, corporate workforce optimization costs, including severance and employee-related costs, other asset impairment and related charges associated with the discontinuation of certain non-core assets, and a stock-based compensation charge. During the third quarter of 2024, the Company finalized an enterprise-wide restructuring plan intended to streamline and simplify the organization, improve efficiency and reduce costs. In connection with this restructuring plan, the Company completed a strategic review of its retail business and determined that it planned to close additional retail stores in 2025, and, accordingly, it recorded a store impairment charge to write down the associated lease right-of-use assets and property and equipment. In addition, during the third quarter of 2024, the Company also conducted a review of its various strategic assets and determined that it would discontinue the use of certain non-core assets, at which time impairment losses were recorded to write down the carrying value of these assets to the Company's best estimate of their fair value. In 2023, the restructuring charges are primarily comprised of severance and employee-related costs, asset impairment charges and a stock-based compensation charge. The restructuring charges associated with the store impairments are reflected within the Pharmacy & Consumer Wellness segment, other asset impairments and related charges are reflected within the Corporate/Other and Pharmacy & Consumer Wellness segments and corporate workforce optimization costs, including severance and employee-related costs, as well as the stock-based compensation charge, are reflected within the Corporate/Other segment.

(11) In 2023, the loss on assets held for sale relates to the long-term care pharmacy ("LTC") business, which was included within the Pharmacy & Consumer Wellness segment prior to the deconsolidation of the Omnicare Entities in September 2025. During 2022, the Company determined that its LTC business was no longer a strategic asset and committed to a plan to sell it, at which time the LTC business met the criteria for held-for-sale accounting and its net assets were accounted for as assets held for sale. During the first quarter of 2023, a loss on assets held for sale was recorded to write down the carrying value of the LTC business to the Company's best estimate of the ultimate selling price which reflected its estimated fair value less costs to sell. As of the third quarter of 2023, the Company determined the LTC business no longer met the criteria for held-for-sale accounting and, at that time, the net assets associated with the LTC business were reclassified to held and used at their respective fair values.

Health Care Benefits Segment

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

	Year Ended December 31,			Change			
				2025 vs. 2024		2024 vs. 2023	
In millions, except percentages and basis points ("bps")	**2025**	**2024**	**2023**	**$**	**%**	**$**	**%**
Revenues:							
Premiums	$ 134,749	$ 122,849	$ 99,144	$ 11,900	9.7 %	$ 23,705	23.9 %
Services	6,823	6,343	5,737	480	7.6 %	606	10.6 %
Net investment income	1,782	1,473	765	309	21.0 %	708	92.5 %
Total revenues	143,354	130,665	105,646	12,689	9.7 %	25,019	23.7 %
Health care costs	122,949	113,659	85,504	9,290	8.2 %	28,155	32.9 %
MBR (Health care costs as a % of premium revenues)	91.2 %	92.5 %	86.2%	(130) bps		630 bps	
Operating expenses	$ 18,612	$ 17,990	$ 16,193	$ 622	3.5 %	$ 1,797	11.1 %
Operating expenses as a % of total revenues	13.0 %	13.8 %	15.3 %				
Operating income (loss)	$ 1,793	$ (984)	$ 3,949	$ 2,777	282.2 %	$ (4,933)	(124.9)%
Operating income (loss) as a % of total revenues	1.3 %	(0.8)%	3.7 %				
Adjusted operating income [(1)]	$ 2,939	$ 307	$ 5,577	$ 2,632	857.3 %	$ (5,270)	(94.5)%
Adjusted operating income as a % of total revenues	2.1 %	0.2 %	5.3 %				
Premium revenues (by business):							
Government	$ 103,362	$ 88,433	$ 70,094	$ 14,929	16.9 %	$ 18,339	26.2 %
Commercial	31,387	34,416	29,050	(3,029)	(8.8)%	5,366	18.5 %

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

Commentary - 2025 compared to 2024

Revenues

- Total revenues increased $12.7 billion, or 9.7%, in 2025 compared to 2024 primarily driven by increases in the Government business, largely due to the impact of the Inflation Reduction Act ("IRA") on the Medicare Part D program.

Medical Benefit Ratio

- Medical benefit ratio is calculated as health care costs divided by premium revenues and represents the percentage of premium revenues spent on medical benefits for the Company's Insured members. Management uses MBR to assess the underlying business performance and underwriting of its insurance products, understand variances between actual results and expected results and identify trends in period-over-period results. MBR provides management and investors with information useful in assessing the operating results of the Company's Insured Health Care Benefits products.
- The MBR decreased to 91.2% in 2025 compared to 92.5% in the prior year primarily driven by improved underlying performance in the Government business and higher favorable prior year development.

Operating expenses

- Operating expenses in the Health Care Benefits segment include selling, general and administrative expenses and depreciation and amortization expenses.
- Operating expenses increased $622 million, or 3.5%, in 2025 compared to 2024 primarily driven by increased investments to support the segment's business operations.

Adjusted operating income

- Adjusted operating income increased $2.6 billion in 2025 compared to 2024 primarily driven by improved underlying performance in the Government business and higher favorable prior year development.

The following table summarizes the Health Care Benefits segment's medical membership as of December 31, 2025 and 2024:

	2025			2024		
In thousands	**Insured**	**ASC**	**Total**	**Insured**	**ASC**	**Total**
Medical membership:						
Commercial	3,447	15,350	18,797	4,691	14,160	18,851
Medicare Advantage	4,267	—	4,267	4,447	—	4,447
Medicare Supplement	1,202	—	1,202	1,282	—	1,282
Medicaid	1,952	373	2,325	2,094	421	2,515
Total medical membership	10,868	15,723	26,591	12,514	14,581	27,095
Supplemental membership information:						
Medicare Prescription Drug Plan (stand-alone)			4,041			4,882

Medical Membership

- Medical membership represents the number of members covered by the Company's Insured and ASC medical products and related services at a specified point in time. Management uses this metric to understand variances between actual medical membership and expected amounts as well as trends in period-over-period results. This metric provides management and investors with information useful in understanding the impact of medical membership on segment total revenues and operating results.
- Medical membership as of December 31, 2025 decreased 504,000 members compared with December 31, 2024, reflecting declines in the individual exchange and Government product lines, partially offset by an increase in Commercial ASC membership.

Medicare Update

On April 7, 2025, CMS issued its final notice detailing final 2026 Medicare Advantage payment rates. Final 2026 Medicare Advantage rates resulted in an expected average increase in revenue for the Medicare Advantage industry of 5.06%, excluding the CMS estimate of Medicare Advantage risk score trend. On January 26, 2026, CMS issued an advance notice detailing proposed 2027 Medicare Advantage payment rates. The 2027 Medicare Advantage rates, if finalized as proposed, will result in an expected average increase in revenue for the Medicare Advantage industry of 0.09%, excluding the CMS estimate of Medicare Advantage risk score trend. CMS intends to publish the final 2027 rate announcement no later than April 6, 2026.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively the "ACA") ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star ratings." Plans must have a star rating of four or higher (out of five) to qualify for bonus payments. CMS released the Company's 2026 star ratings in October 2025. The Company's 2026 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 2027. Based on the Company's membership as of December 2025, more than 81% of the Company's Medicare Advantage members were in plans with 2026 star ratings of at least 4.0 stars, compared to 88% of the Company's Medicare Advantage members being in plans with 2025 star ratings of at least 4.0 stars based on the Company's membership as of December 2024.

Health Services Segment

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

	Year Ended December 31,			Change			
				2025 vs. 2024		2024 vs. 2023	
In millions, except percentages	**2025**	**2024**	**2023**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ 180,927	$ 162,436	$ 180,608	$ 18,491	11.4 %	$ (18,172)	(10.1)%
Services	9,478	10,884	6,236	(1,406)	(12.9)%	4,648	74.5 %
Net investment income (loss) [1]	20	285	(1)	(265)	(93.0)%	286	NM
Total revenues	190,425	173,605	186,843	16,820	9.7 %	(13,238)	(7.1)%
Cost of products sold	175,634	160,036	175,424	15,598	9.7 %	(15,388)	(8.8)%
Health care costs	4,834	3,407	1,607	1,427	41.9 %	1,800	112.0 %
Operating expenses	4,012	3,225	2,970	787	24.4 %	255	8.6 %
Operating expenses as a % of total revenues	2.1 %	1.9 %	1.6 %				
Goodwill impairment	$ 5,725	$ —	$ —	$ 5,725	100.0 %	$ —	— %
Operating income	220	6,937	6,842	(6,717)	(96.8)%	95	1.4 %
Operating income as a % of total revenues	0.1 %	4.0 %	3.7 %				
Adjusted operating income [2]	$ 7,151	$ 7,243	$ 7,312	$ (92)	(1.3)%	$ (69)	(0.9)%
Adjusted operating income as a % of total revenues	3.8 %	4.2 %	3.9 %				
Revenues (by distribution channel):							
Pharmacy network [3]	$ 101,775	$ 91,650	$ 112,718	$ 10,125	11.0 %	$ (21,068)	(18.7)%
Mail & specialty [4]	79,334	70,877	67,992	8,457	11.9 %	2,885	4.2 %
Other	9,296	10,793	6,134	(1,497)	(13.9)%	4,659	76.0 %
Net investment income (loss) [1]	20	285	(1)	(265)	(93.0)%	286	NM
Pharmacy claims processed [5]	1,900.7	1,917.6	2,344.3	(16.9)	(0.9)%	(426.7)	(18.2)%

(1) NM represents a percent change that is not meaningful.

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

(3) Pharmacy network revenues relate to claims filled at retail and specialty retail pharmacies, including pharmacies owned by the Company, as well as activity associated with Maintenance Choice, 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.

(4) Mail & specialty revenues relate to specialty mail claims inclusive of Specialty Connect® claims picked up at a retail pharmacy, as well as mail order and specialty claims fulfilled by the Pharmacy & Consumer Wellness segment.

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

Commentary - 2025 compared to 2024

Revenues

- Total revenues increased $16.8 billion, or 9.7%, in 2025 compared to 2024 primarily driven by pharmacy drug mix and brand inflation, partially offset by continued pharmacy client price improvements.

Operating expenses

- Operating expenses in the Health Services segment include selling, general and administrative expenses; and depreciation and amortization expense.
- Operating expenses increased $787 million, or 24.4%, in 2025 compared to 2024. The increase was primarily due to a $291 million litigation charge, $288 million in pre-tax losses on Accountable Care assets and an $83 million Health Care Delivery clinic closure charge, all recorded during 2025.

Goodwill impairment

- In 2025, the Company recorded a $5.7 billion goodwill impairment charge related to the Health Care Delivery reporting unit within the Health Services segment. See Note 6 ‘‘Goodwill and Other Intangibles’’ included in Item 8 of this 10-K for additional information.

Adjusted operating income

- Adjusted operating income decreased $92 million, or 1.3%, in 2025 compared to 2024. The decrease in adjusted operating income was primarily driven by continued pharmacy client price improvements and the impact of a higher medical benefit ratio in the Company’s health care delivery business, partially offset by improved purchasing economics and pharmacy drug mix.

Pharmacy claims processed

- Pharmacy claims processed represents the number of prescription claims processed through the Company’s pharmacy benefits manager and dispensed by either its retail network pharmacies or the Company’s mail and specialty pharmacies. Management uses this metric to understand variances between actual claims processed and expected amounts as well as trends in period-over-period results. This metric provides management and investors with information useful in understanding the impact of pharmacy claim volume on segment total revenues and operating results.
- The Company’s pharmacy claims processed decreased 0.9% on a 30-day equivalent basis in 2025 compared to 2024.

Pharmacy & Consumer Wellness Segment

The following table summarizes the Pharmacy & Consumer Wellness segment's performance for the respective periods:

	Year Ended December 31,			Change			
				2025 vs. 2024		2024 vs. 2023	
In millions, except percentages	**2025**	**2024**	**2023**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ 136,575	$ 122,028	$ 113,976	$ 14,547	11.9 %	$ 8,052	7.1 %
Services	2,792	2,472	2,792	320	12.9 %	(320)	(11.5)%
Net investment income (loss)	—	—	(5)	—	— %	5	100.0 %
Total revenues	139,367	124,500	116,763	14,867	11.9 %	7,737	6.6 %
Cost of products sold	113,583	99,337	91,447	14,246	14.3 %	7,890	8.6 %
Operating expenses	20,924	19,646	19,618	1,278	6.5 %	28	0.1 %
Operating expenses as a % of total revenues	15.0 %	15.8 %	16.8 %				
Restructuring charges	$ —	$ 747	$ —	$ (747)	(100.0)%	$ 747	100.0 %
Loss on assets held for sale	—	—	349	—	— %	(349)	(100.0)%
Operating income	4,860	4,770	5,349	90	1.9 %	(579)	(10.8)%
Operating income as a % of total revenues	3.5 %	3.8 %	4.6 %				
Adjusted operating income [1]	$ 6,040	$ 5,774	$ 5,963	$ 266	4.6 %	$ (189)	(3.2)%
Adjusted operating income as a % of total revenues	4.3 %	4.6 %	5.1 %				
Revenues (by major goods/service lines):							
Pharmacy	$ 115,510	$ 100,687	$ 92,111	$ 14,823	14.7 %	$ 8,576	9.3 %
Front Store	21,459	21,522	22,458	(63)	(0.3)%	(936)	(4.2)%
Other	2,398	2,291	2,199	107	4.7 %	92	4.2 %
Net investment income (loss)	—	—	(5)	—	— %	5	100.0 %
Prescriptions filled [2]	1,808.8	1,715.5	1,649.1	93.3	5.4 %	66.4	4.0 %
Same store sales increase (decrease): [3]							
Total	15.0 %	9.4 %	10.7 %				
Pharmacy	18.0 %	12.3 %	13.6 %				
Front Store	1.2 %	(2.1)%	0.3 %				
Prescription volume [2]	8.0 %	6.8 %	3.9 %				

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

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

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

Commentary - 2025 compared to 2024

Revenues

- Total revenues increased $14.9 billion, or 11.9%, in 2025 compared to 2024. The increase was primarily driven by pharmacy drug mix and increased prescription volume, including incremental volume resulting from the Company's Rite Aid prescription file acquisitions, partially offset by continued pharmacy reimbursement pressure and the impact of recent generic drug introductions.

- Pharmacy same store sales increased 18.0% in 2025 compared to 2024. The increase was primarily driven by pharmacy drug mix, including branded GLP-1 drugs, and the 8.0% increase in pharmacy same store prescription volume on a 30-day equivalent basis. These increases were partially offset by continued pharmacy reimbursement pressure and the impact of recent generic drug introductions.
- Front store same store sales increased 1.2% in 2025 compared to 2024.

Operating expenses
- Operating expenses in the Pharmacy & Consumer Wellness segment include payroll, employee benefits and occupancy costs associated with the segment's stores and pharmacy fulfillment operations; selling expenses; advertising expenses; depreciation and amortization expense and certain administrative expenses.
- Operating expenses increased $1.3 billion, or 6.5%, in 2025 compared to 2024. The increase in operating expenses was primarily due to $929 million in litigation charges recorded in 2025 related to the Omnicare long-term care business and increased investments in the segment's colleagues and capabilities.

Restructuring charges
- During 2024, the Company recorded $747 million of restructuring charges related to the write-down of lease right-of-use assets and property and equipment in connection with the Company's restructuring program. See Note 3 ''Restructuring'' included in Item 8 of this 10-K for additional information.

Adjusted operating income
- Adjusted operating income increased $266 million, or 4.6%, in 2025 compared to 2024 primarily driven by increased prescription volume, including incremental volume resulting from the Company's Rite Aid prescription file acquisitions, as well as favorable drug mix, partially offset by continued pharmacy reimbursement pressure and increased investments in the segment's colleagues and capabilities.

Prescriptions filled
- Prescriptions filled represents the number of prescriptions dispensed through the Pharmacy & Consumer Wellness segment's retail pharmacies and infusion services operations, as well as through the Omnicare long-term care pharmacies prior to their deconsolidation during the third quarter of 2025. Management uses this metric to understand variances between actual prescriptions dispensed and expected amounts as well as trends in period-over-period results. This metric provides management and investors with information useful in understanding the impact of prescription volume on segment total revenues and operating results.
- Prescriptions filled increased 5.4% on a 30-day equivalent basis in 2025 compared to 2024 primarily driven by increased utilization and incremental volume resulting from the Company's Rite Aid prescription file acquisitions.

Corporate/Other Segment

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

	Year Ended December 31,			Change			
				2025 vs. 2024		2024 vs. 2023	
In millions, except percentages	**2025**	**2024**	**2023**	**$**	**%**	**$**	**%**
Revenues:							
Premiums	$ 45	$ 47	$ 48	$ (2)	(4.3)%	$ (1)	(2.1)%
Services	8	9	9	(1)	(11.1)%	—	— %
Net investment income	431	395	394	36	9.1 %	1	0.3 %
Total revenues	484	451	451	33	7.3 %	—	— %
Cost of products sold	—	—	1	—	— %	(1)	(100.0)%
Health care costs	177	187	210	(10)	(5.3)%	(23)	(11.0)%
Operating expenses	2,520	2,039	2,130	481	23.6 %	(91)	(4.3)%
Restructuring charges	—	432	507	(432)	(100.0)%	(75)	(14.8)%
Operating loss	(2,213)	(2,207)	(2,397)	(6)	(0.3)%	190	7.9 %
Adjusted operating loss [(1)]	(1,687)	(1,348)	(1,318)	(339)	(25.1)%	(30)	(2.3)%

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

Commentary - 2025 compared to 2024

Revenues

- Revenues primarily relate to products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products.
- Total revenues increased $33 million, or 7.3%, in 2025 compared to 2024 primarily driven by higher net investment income driven by higher fixed income assets.

Restructuring charges

- During 2024, the Company recorded $432 million of restructuring charges comprised of $129 million of asset impairment and related charges associated with the write-down of certain non-core assets, $293 million of severance and employee-related costs associated with corporate workforce optimization and a $10 million stock-based compensation charge associated with the impacted employees. See Note 3 ''Restructuring'' included in Item 8 of this 10-K for additional information.

Adjusted operating loss

- Adjusted operating loss increased $339 million, or 25.1%, in 2025 compared to 2024 primarily driven by increased investments in colleagues and capabilities.

Liquidity and Capital Resources

Cash Flows

The Company maintains a level of liquidity sufficient to allow it to meet its cash needs in the short-term. Over the long term, the Company manages its cash and capital structure to maximize shareholder return, maintain its financial condition and maintain flexibility for future strategic initiatives. The Company continuously assesses its regulatory capital requirements, working capital needs, debt and leverage levels, debt maturity schedule, capital expenditure requirements, dividend payouts, potential share repurchases and future investments or acquisitions. The Company believes its operating cash flows, commercial paper program, credit facilities, as well as any potential future borrowings, will be sufficient to fund these future payments and long-term initiatives. As of December 31, 2025, the Company had approximately $8.5 billion in cash and cash equivalents, approximately $2.8 billion of which was held by the parent company or nonrestricted subsidiaries.

The net change in cash, cash equivalents and restricted cash for the years ended December 31, 2025, 2024 and 2023 was as follows:

				Change			
	Year Ended December 31,			2025 vs. 2024		2024 vs. 2023	
In millions	2025	2024	2023	$	%	$	%
Net cash provided by operating activities	$ 10,639	$ 9,107	$ 13,426	$ 1,532	16.8 %	$ (4,319)	(32.2)%
Net cash used in investing activities	(5,871)	(7,613)	(20,889)	1,742	22.9 %	13,276	63.6 %
Net cash provided by (used in) financing activities	(4,940)	(1,135)	2,683	(3,805)	(335.2)%	(3,818)	(142.3)%
Net increase (decrease) in cash, cash equivalents and restricted cash	$ (172)	$ 359	$ (4,780)	$ (531)	(147.9)%	$ 5,139	107.5 %

Commentary - 2025 compared to 2024

- *Net cash provided by operating activities* increased by $1.5 billion in 2025 compared to 2024 primarily due to the timing of payments and receipts and the impact of improved operating performance in the Health Care Benefits segment.
- *Net cash used in investing activities* decreased by $1.7 billion in 2025 compared to 2024 primarily due to higher proceeds from sales and maturities of investments, partially offset by cash paid to acquire the prescription files of certain Rite Aid pharmacies. In addition, cash used in investing activities reflected the following activity:
    - Gross capital expenditures were approximately $2.8 billion in both 2025 and 2024. During 2025, approximately 77% of the Company's total capital expenditures were for technology, digital and other strategic initiatives and 23% were for store, fulfillment and support facilities and equipment expansion and improvements.
- *Net cash used in financing activities* increased by $3.8 billion in 2025 compared to 2024 primarily due to higher repayments of commercial paper and lower proceeds from the issuance of long-term senior notes in 2025, partially offset by higher share repurchases and repayments of long-term debt in 2024.

Included in net cash used in investing activities for the years ended December 31, 2025, 2024 and 2023 was the following store development activity: [(1)]

	2025	2024	2023
Total stores (beginning of year)	9,135	9,395	9,674
New and acquired stores [(2)]	87	39	39
Closed stores [(2)]	(243)	(299)	(318)
Total stores (end of year)	8,979	9,135	9,395
Relocated stores [(2)]	5	3	5

(1) Includes retail drugstores and pharmacies within retail chains, primarily in Target Corporation ("Target") stores.
(2) Relocated stores are not included in new and acquired stores or closed stores totals.

Short-term Borrowings

Commercial Paper and Back-up Credit Facilities
The Company did not have any commercial paper outstanding as of December 31, 2025. The Company had $2.1 billion of commercial paper outstanding at a weighted interest rate of 4.98% as of December 31, 2024. In connection with its commercial paper program, the Company maintains three $2.5 billion, five-year unsecured back-up revolving credit facilities, which expire in May 2028, 2029 and 2030. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately 0.03%, regardless of usage. As of December 31, 2025 and 2024, there were no borrowings outstanding under any of the Company's back-up credit facilities.

Term Loan Agreement
On March 25, 2024, the Company entered into a 364-day $3.0 billion term loan credit agreement. The term loan credit agreement allowed for borrowings at various rates that were dependent, in part, on the Company's public debt ratings. On May 9, 2024, following the issuance of the $5.0 billion in senior notes described under "Long-term Borrowings" below, the term loan credit agreement terminated. There were no borrowings under the term loan credit agreement through the date of termination.

Federal Home Loan Bank of Boston ("FHLBB")
A subsidiary of the Company is a member of the FHLBB. As a member, the subsidiary has the ability to obtain cash advances, subject to certain minimum collateral requirements. The maximum borrowing capacity available from the FHLBB as of December 31, 2025 was approximately $1.3 billion. As of December 31, 2025 and 2024, there were no outstanding advances from the FHLBB.

Long-term Borrowings

2025 Notes
On August 15, 2025, the Company issued $750 million aggregate principal amount of 5.0% senior notes due September 2032, $1.5 billion aggregate principal amount of 5.45% senior notes due September 2035, $1.25 billion aggregate principal amount of 6.2% senior notes due September 2055 and $500 million aggregate principal amount of 6.25% senior notes due September 2065 for total proceeds of approximately $4.0 billion, net of discounts and underwriting fees. The net proceeds of these offerings were used to repay existing indebtedness, including borrowings under the Company's commercial paper program, as well as for general corporate purposes.

2024 Notes
On December 10, 2024, the Company issued $2.25 billion aggregate principal amount of 7.0% fixed-to-fixed rate series A junior subordinated notes due March 2055 and $750 million aggregate principal amount of 6.75% fixed-to-fixed rate series B junior subordinated notes due December 2054 for total proceeds of approximately $3.0 billion, net of discounts and underwriting fees. The series A junior subordinated notes bear interest at 7.0% per year until March 10, 2030, at which time the rate will reset March 10th of every fifth year, provided that the interest rate will not reset below the initial interest rate. The series B junior subordinated notes bear interest at 6.75% per year until December 10, 2034, at which time the rate will reset December 10th of every fifth year, provided that the interest rate will not reset below the initial interest rate. The series A and series B junior subordinated notes pay interest semi-annually and may be redeemed at any time beginning 90 days prior to their respective first interest rate reset date and on any interest payment date thereafter, in whole or in part at a defined redemption price plus accrued interest. The net proceeds of these offerings were used for the early extinguishment of certain of the Company's senior notes as described below and the remaining proceeds after the early extinguishment of debt were used for general corporate purposes.

On May 9, 2024, the Company issued $1.0 billion aggregate principal amount of 5.4% senior notes due June 2029, $1.0 billion aggregate principal amount of 5.55% senior notes due June 2031, $1.25 billion aggregate principal amount of 5.7% senior notes due June 2034, $750 million aggregate principal amount of 6.0% senior notes due June 2044 and $1.0 billion aggregate principal amount of 6.05% senior notes due June 2054 for total proceeds of approximately $5.0 billion, net of discounts and underwriting fees. The net proceeds of these offerings were used for general corporate purposes.

Gain on Early Extinguishment of Debt
In December 2024, pursuant to a cash tender offer, the Company repaid approximately $2.6 billion of its outstanding senior notes for a cash payment of approximately $2.0 billion. The senior notes purchased include: $226 million of its 4.1% senior notes due March 2025, $398 million of its 4.125% senior notes due April 2040, $883 million of its 2.7% senior notes due

August 2040, $274 million of its 4.125% senior notes due November 2042, $463 million of its 3.875% senior notes due August 2047 and $351 million of its 4.25% senior notes due April 2050. In connection with the purchase of such senior notes, the Company recognized a total gain on early extinguishment of debt of $491 million, net of unamortized deferred financing costs and incurred fees.

See Note 10 ‘‘Borrowings and Credit Agreements’’ included in Item 8 of this 10-K for additional information about debt issuances and debt repayments.

Derivative Financial Instruments

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

Debt Covenants

The Company’s back-up revolving credit facilities and unsecured senior notes (see Note 10 ‘‘Borrowings and Credit Agreements’’ included in Item 8 of this 10-K) contain customary restrictive financial and operating covenants. These covenants do not include an acceleration of the Company’s debt maturities in the event of a downgrade in the Company’s credit ratings. The Company does not believe the restrictions contained in these covenants materially affect its financial or operating flexibility. As of December 31, 2025, the Company was in compliance with all of its debt covenants.

Debt Ratings

As of December 31, 2025, the Company’s long-term debt was rated “BBB” by Fitch Ratings, Inc. (“Fitch”), “Baa3” by Moody’s Investors Service, Inc. (“Moody’s”) and “BBB” by Standard & Poor’s Financial Services LLC (“S&P”), and its commercial paper program was rated “F2” by Fitch, “P-3” by Moody’s and “A-2” by S&P. The outlook on the Company’s long-term debt is “Negative” by both Fitch and S&P and “Stable” by Moody’s. In assessing the Company’s credit strength, the Company believes that Fitch, 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, including the Company’s expectations for future earnings and cash flows. Although the Company currently believes its long-term debt ratings will remain investment grade, it cannot predict the future actions of Moody’s, S&P and/or Fitch. 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

The following share repurchase programs have been authorized by CVS Health Corporation’s Board of Directors (the “Board”):

In billions **Authorization Date**	**Authorized**	**Remaining as of December 31, 2025**
November 17, 2022 (“2022 Repurchase Program”)	$ 10.0	$ 10.0
December 9, 2021 (“2021 Repurchase Program”)	10.0	1.5

Each of the share Repurchase Programs was effective immediately and 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. Both the 2022 and 2021 Repurchase Programs can be modified or terminated by the Board at any time.

During the year ended December 31, 2025, the Company did not repurchase any shares of its common stock. During the years ended December 31, 2024 and 2023, the Company repurchased an aggregate of 39.7 million shares of common stock for approximately $3.0 billion and an aggregate of 22.8 million shares of common stock for approximately $2.0 billion, respectively, each pursuant to the 2021 Repurchase Program. This activity includes the share repurchases under the ASR transactions described below.

Pursuant to the authorization under the 2021 Repurchase Program, the Company entered into a $3.0 billion fixed dollar ASR with Morgan Stanley & Co. LLC. Upon payment of the $3.0 billion purchase price on January 4, 2024, the Company received a number of shares of CVS Health Corporation’s common stock equal to 85% of the $3.0 billion notional amount of the ASR or approximately 31.4 million shares, which were placed into treasury stock in January 2024. The ASR was accounted for as an

initial treasury stock transaction for $2.6 billion and a forward contract for $0.4 billion. The forward contract was classified as an equity instrument and was recorded within capital surplus. In March 2024, the Company received approximately 8.3 million shares of CVS Health Corporation's common stock, representing the remaining 15% of the $3.0 billion notional amount of the ASR, thereby concluding the ASR. These shares were placed into treasury and the forward contract was reclassified from capital surplus to treasury stock in March 2024.

Pursuant to the authorization under the 2021 Repurchase Program, the Company entered into a $2.0 billion fixed dollar ASR with Citibank, N.A. Upon payment of the $2.0 billion purchase price on January 4, 2023, the Company received a number of shares of CVS Health Corporation's common stock equal to 80% of the $2.0 billion notional amount of the ASR or approximately 17.4 million shares, which were placed into treasury stock in January 2023. The ASR was accounted for as an initial treasury stock transaction for $1.6 billion and a forward contract for $0.4 billion. The forward contract was classified as an equity instrument and was recorded within capital surplus. In February 2023, the Company received approximately 5.4 million shares of CVS Health Corporation's common stock, representing the remaining 20% of the $2.0 billion notional amount of the ASR, thereby concluding the ASR. These shares were placed into treasury stock and the forward contract was reclassified from capital surplus to treasury stock in February 2023.

At the time they were received, the initial and final receipt of shares resulted in an immediate reduction of the outstanding shares used to calculate the weighted average common shares outstanding for basic and diluted earnings per share.

Dividends

The quarterly cash dividend declared by the Board was $0.665 per share in 2025 and 2024 and $0.605 per share in 2023. CVS Health Corporation has paid cash dividends every quarter since becoming a public company and expects to maintain its quarterly dividend of $0.665 per share throughout 2026. Future dividend payments will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

Future Cash Requirements

The following table summarizes certain estimated future cash requirements under the Company's various contractual obligations at December 31, 2025, in total and disaggregated into current and long-term obligations. The table below does not include future payments of claims to health care providers or pharmacies because certain terms of these payments are not determinable at December 31, 2025 (for example, the timing and volume of future services provided under fee-for-service arrangements and future membership levels for capitated arrangements).

In millions	Total	Current	Long-Term
Operating lease liabilities [1]	$ 19,387	$ 2,626	$ 16,761
Finance lease liabilities [1]	1,960	139	1,821
Contractual lease obligations with Target [2]	2,268	—	2,268
Long-term debt [3]	63,709	4,007	59,702
Interest payments on long-term debt [3]	44,003	2,933	41,070
Opioid litigation settlement obligations [4]	3,975	648	3,327
Other long-term liabilities on the consolidated balance sheets [5]			
Future policy benefits [6]	4,477	360	4,117
Unpaid claims [6]	801	202	599
Policyholders' funds [6] [7]	937	615	322
Total	$ 141,517	$ 11,530	$ 129,987

(1) Refer to Note 7 ''Leases'' included in Item 8 of this 10-K for additional information regarding the maturity of lease liabilities under operating and finance leases.

(2) The Company leases pharmacy and clinic space from Target. See Note 7 ''Leases'' included in Item 8 of this 10-K for additional information regarding the lease arrangements with Target. Amounts related to such operating and finance leases are reflected within the operating lease liabilities and finance lease liabilities in the table above. Pharmacy lease amounts due in excess of the remaining estimated economic life of the buildings are reflected in the table above assuming equivalent stores continue to operate through the term of the arrangements.

(3) Refer to Note 10 ''Borrowings and Credit Agreements'' included in Item 8 of this 10-K for additional information regarding the maturities of debt principal. Interest payments on long-term debt are calculated using outstanding balances and interest rates in effect on December 31, 2025.

(4) Refer to Note 18 ''Commitments and Contingencies'' included in Item 8 of this 10-K for additional information regarding the opioid litigation settlement obligations.

(5) Payments of other long-term liabilities exclude Separate Accounts liabilities of approximately $2.0 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.

(6) Total payments of future policy benefits, unpaid claims and policyholders' funds include $547 million, $761 million and $125 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.

(7) Customer funds associated with group life and health contracts of approximately $9 million 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 losses on debt securities supporting experience-rated products of $6 million, before tax, have been excluded from the table above.

Restrictions on Certain Payments

In addition to general state law restrictions on payments of dividends and other distributions to stockholders applicable to all corporations, health maintenance organizations ("HMOs") and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity (referred to as surplus) and restrict the amount of dividends and other distributions that may be paid to their equity holders. These regulations are not directly applicable to CVS Health Corporation as a holding company since CVS Health Corporation is not an HMO or an insurance company. In addition, in connection with the Aetna Acquisition, the Company made certain undertakings that require prior regulatory approval of dividends by certain of its HMOs and insurance companies. The additional regulations and undertakings applicable to the Company's HMO and insurance company subsidiaries are not expected to affect the Company's ability to service the Company's debt, meet other financing obligations or pay dividends, or the ability of any of the Company's subsidiaries to service their debt or other financing obligations. Under applicable regulatory requirements and undertakings, at December 31, 2025, the maximum amount of dividends that may be paid by the Company's insurance and HMO subsidiaries without prior approval by regulatory authorities was $3.8 billion in the aggregate.

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

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, 2025, all of the Company's insurance and HMO subsidiaries were above the RBC 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, 2025, at that date each of the Company's active HMOs had a surplus that exceeded either the applicable state net worth requirements or, where adopted, the levels that would require regulatory action under the NAIC's RBC rules. External rating agencies use their own capital models and/or RBC standards when they determine a company's rating.

Critical Accounting Policies

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

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

Revenue Recognition

Health Care Benefits Segment
Health Care Benefits revenue is principally derived from insurance premiums and fees billed to customers. Revenue related to the Company’s Government business is collected monthly from the U.S. federal government and various government agencies based on fixed payment rates and member eligibility.

Some of the Company’s Government 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.

Health Services Segment
The Health Services segment sells prescription drugs directly through its specialty and mail order pharmacy offerings 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 fulfillment 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 fulfilled indirectly through its retail pharmacy network because it has separate contractual arrangements with those pharmacies, has discretion in setting the price for the transaction and assumes primary responsibility for fulfilling the promise to provide prescription drugs to its client plan members while also performing the related PBM services.

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

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

- Revenues generated from prescription drugs sold by third party pharmacies in the Company’s retail pharmacy network and associated administrative fees are recognized at the Company’s point-of-sale, which is when the claim is adjudicated by the Company’s online claims processing system and the Company has transferred control of the prescription drug and completed all of its performance obligations.
- Revenues generated from prescription drugs sold by specialty and mail order 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.

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

Drug Discounts

The Company records revenue net of manufacturers' rebates earned by its clients based on their plan members' utilization of brand-name formulary drugs. The Company estimates these rebates at period-end based on actual and estimated claims data and its estimates of the manufacturers' rebates earned by its clients. The estimates are based on the best available data at period-end and recent history for the various factors that can affect the amount of rebates due to the client. The Company adjusts its rebates payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. Any cumulative effect of these adjustments is recorded against revenues at the time it is identified. Adjustments generally result from contract changes with clients or manufacturers that have retroactive rebate adjustments, differences between the estimated and actual product mix subject to rebates, or whether the brand name drug was included in the applicable formulary. The effect of adjustments between estimated and actual manufacturers' rebate amounts has not been material to the Company's operating results or financial condition.

Impairments of Debt Securities

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

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

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

During the years ended December 31, 2025, 2024 and 2023, the Company recorded yield-related impairment losses on debt securities of $28 million, $73 million and $152 million, respectively. The Company did not record any credit-related losses on debt securities during the year ended December 31, 2025. During the years ended December 31, 2024 and 2023, credit-related losses on debt securities were not material.

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.

Inventory

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

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

The total reserve for estimated inventory losses covered by this critical accounting policy was $635 million and $600 million as of December 31, 2025 and 2024, respectively. Although management believes there is sufficient current and historical information available to record reasonable estimates for estimated inventory losses, it is possible that actual results could differ. In order to help investors assess the aggregate risk, if any, associated with the inventory-related uncertainties discussed above, a ten percent (10%) pre-tax change in estimated inventory losses, which is a reasonably likely change, would increase or decrease the total reserve for estimated inventory losses by approximately $64 million as of December 31, 2025.

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.

Recoverability of Long-Lived Assets

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

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

During the third quarter of 2024, in connection with its enterprise-wide restructuring plan, the Company completed a strategic review of its retail business, which included evaluating changes in population, consumer buying patterns and future health requirements to ensure continued alignment of its retail footprint with consumer needs. In connection with this initiative, in September 2024, the Company determined it planned to close 271 retail stores in 2025. As a result, management determined that there were indicators of impairment with respect to the impacted stores' asset groups, including the associated operating or financing lease right-of-use assets and property and equipment. A long-lived asset impairment test was performed during the third quarter of 2024, the results of which indicated that the fair value of certain retail store asset groups were lower than their respective carrying values. Accordingly, in the three months ended September 30, 2024, the Company recorded a store impairment charge of $607 million, consisting of a write down of $483 million related to operating and financing lease right-of-use assets and $124 million related to property and equipment. The charge associated with the store impairments was included in the restructuring charges within the Pharmacy & Consumer Wellness segment.

Recoverability of Goodwill

Goodwill represents the excess of amounts paid for acquisitions over the fair value of the net identifiable assets acquired. Goodwill is subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable. Goodwill is tested for impairment on a reporting unit basis. The impairment test is performed by comparing the reporting unit's fair value with its net book value (or carrying amount), including goodwill. The fair value of the reporting units is estimated using a combination of a discounted cash flow method and a market multiple method. If the net book value (carrying amount) of the reporting unit exceeds its fair value, the reporting unit's goodwill is considered to be impaired, and an impairment is recognized in an amount equal to the excess.

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

2025 Goodwill Impairment Test

During the fourth quarter of 2025, the Company performed its required annual impairment test of goodwill. The results of the impairment tests indicated that there was no impairment of goodwill as of the testing date. The fair values of the reporting units with goodwill exceeded their carrying values by significant margins, with the exception of the Health Care Delivery reporting unit, which exceeded its carrying value by approximately 3%.

During 2025, the Health Care Delivery reporting unit continued to experience challenges, including the impact of persistent elevated utilization levels. In order to best respond to these challenges, the Company made a number of changes to its Health Care Delivery management team during 2025. During the third quarter of 2025, this new management team finalized certain strategic changes, including the determination that it would reduce the number of new primary care clinics it would open in 2026 and annually thereafter. The Company also determined that it would close certain existing Oak Street Health clinics in 2026. The strategy changes were presented to CVS Health Corporation's Board of Directors in September 2025.

These changes are expected to impact management's ability to grow the business at the rate that was originally estimated when the Company acquired the associated care delivery assets in 2023 and when the prior year annual goodwill impairment test was performed. Accordingly, the Health Care Delivery management team updated its financial projections to reflect these changes for 2026 and beyond. Based on these updated projections, management determined that there were indicators that the Health Care Delivery reporting unit's goodwill may be impaired and, accordingly, an interim goodwill impairment test was performed during the third quarter of 2025.

The results of the impairment test showed that the fair value of the Health Care Delivery reporting unit was lower than its carrying value, resulting in a $5.7 billion goodwill impairment charge, which was recorded during the third quarter of 2025. The fair value of the Health Care Delivery 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, lower market multiples of the peer group companies contributed to the amount of the goodwill impairment charge.

Although the Company believes the financial projections used to determine the fair value of the Health Care Delivery reporting unit were reasonable and achievable, continued utilization pressure, insufficient CMS Medicare rate increases relative to underlying medical cost trend or further reductions to the number of existing primary care centers or new primary care center openings may affect the Company's ability to increase operating results in the Health Care Delivery reporting unit at the rate estimated when such goodwill impairment test was performed. Some of the key assumptions included in the Company's financial projections to determine the estimated fair value of its Health Care Delivery reporting unit include future revenue growth rates, including the impact of annual new primary care center openings, and operating income. The estimated fair value of the Health Care Delivery reporting unit is also dependent on multiples of market participants in the care delivery industry, as well as the risk-free interest rate environment which impacts the discount rate used in the discounted cash flow method. If the Company does not achieve its forecasts, given that the fair value and the carrying value of the Health Care Delivery reporting unit were the same following the goodwill impairment charge recorded during the third quarter of 2025, it is reasonably

possible in the near term that the goodwill of the Health Care Delivery reporting unit could be deemed to be impaired again by a material amount. As of December 31, 2025, the remaining goodwill balance in the Health Care Delivery reporting unit was approximately $4.2 billion.

2024 Goodwill Impairment Test

During the fourth quarter of 2024, the Company performed its required annual impairment test of goodwill. The results of the impairment tests indicated that there was no impairment of goodwill as of the testing date. The fair values of the reporting units with goodwill exceeded their carrying values by significant margins, with the exception of the Government reporting unit and the Health Care Delivery reporting unit which exceeded their carrying values by approximately 4% and 8%, respectively.

2023 Goodwill Impairment Test

During the fourth quarter of 2023, the Company performed its required annual impairment test of goodwill. The results of the impairment tests indicated that there was no impairment of goodwill as of the testing date. The fair values of the reporting units with goodwill exceeded their carrying values by significant margins, with the exception of the Health Care Delivery reporting unit, which exceeded its carrying value by approximately 9%.

Recoverability of Indefinite-Lived Intangible Assets

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

The indefinite-lived intangible asset impairment loss calculation contains uncertainty since management must use judgment to estimate fair value based on the assumption that, in lieu of ownership of an intangible asset, the Company would be willing to pay a royalty in order to utilize the benefits of the asset. Fair value is estimated by discounting the hypothetical royalty payments to their present value over the estimated economic life of the asset. These estimates can be affected by a number of factors including general economic conditions, availability of market information and the profitability of the Company. There were no impairment losses recognized on indefinite-lived intangible assets in the years ended December 31, 2025, 2024 or 2023.

Health Care Benefits' IBNR Liabilities

The Health Care Benefits segment's health care costs payable include estimates of the ultimate cost of (i) services rendered to the segment's Insured members but not yet reported to the Company and (ii) claims which have been reported to the Company but not yet paid (collectively, "IBNR"). Health care costs payable also include an estimate of the cost of services that will continue to be rendered after the financial statement date if the Company is obligated to pay for such services in accordance with contractual or regulatory requirements. IBNR estimates are developed using actuarial principles and assumptions that consider numerous factors. See Note 1 ''Significant Accounting Policies'' included in Item 8 of this 10-K for additional information on the Company's reserving methodology.

During 2025 and 2024, the segment observed an increase in completion factors relative to those assumed at the prior year end. After considering the claims paid in 2025 and 2024 with dates of service prior to the fourth quarter of the previous year, the segment observed assumed incurred claim weighted average completion factors that were 31 and 23 basis points higher, respectively, than previously estimated, resulting in a decrease of $541 million and $339 million in 2025 and 2024, respectively, in health care costs payable that related to the prior year. The segment 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, 2025. However, based on historical claim experience, it is reasonably possible that the estimated weighted average completion factors may vary by plus or minus 14 basis points from the assumed rates, which could impact health care costs payable by approximately plus or minus $372 million pretax.

Also, during 2025 and 2024, the Health Care Benefits segment observed that health care costs for claims with claim incurred dates of three months or less before the financial statement date were lower than previously estimated. Specifically, after considering the claims paid in 2025 and 2024 with claim incurred dates for the fourth quarter of the previous year, the segment observed health care costs that were 6.1% and 3.2% lower, respectively, for each fourth quarter than previously estimated, resulting in a reduction of $1.4 billion and $546 million in 2025 and 2024, respectively, in health care costs payable that related to prior year.

Management considers historical health care cost trend rates together with its knowledge of recent events that may impact current trends when developing estimates of current health care cost trend rates. When establishing reserves as of December 31, 2025, the segment increased its assumed health care cost trend rates for the most recent three months by 4.4% from health care cost trend rates recently observed. Based on historical claim experience, it is reasonably possible that the segment'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 $805 million pretax.

New Accounting Pronouncements

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

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

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

Evaluation of Interest Rate and Credit Quality Risk

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

Investments
The Company's investment portfolio supported the following products at December 31, 2025 and 2024:

In millions	**2025**	**2024**
Experience-rated products	$ 578	$ 652
Remaining products	34,236	30,689
Total investments	$ 34,814	$ 31,341

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

The debt securities in the Company's investment portfolio had an average credit quality rating of A at both December 31, 2025 and 2024, with a fair value of approximately $6.2 billion and $5.9 billion rated AAA at December 31, 2025 and 2024, respectively. The fair value of debt securities that were rated below investment grade (that is, having a credit quality rating below BBB-/Baa3) was $2.8 billion and $2.4 billion at December 31, 2025 and 2024, respectively (of which 1.1% and 1.6% at December 31, 2025 and 2024, respectively, supported experience-rated products).

At December 31, 2025 and 2024, the Company held $46 million and $82 million, respectively, of municipal debt securities that were guaranteed by third parties, representing less than 1% of total investments at both December 31, 2025 and 2024. These securities had an average credit quality rating of AA+ at both December 31, 2025 and 2024, with the guarantee and an average credit quality rating of AA+ and AA at December 31, 2025 and 2024, respectively, without the guarantee. The Company does not have any significant concentration of investments with third party guarantors (either direct or indirect).

The Company generally classifies debt securities as available for sale, and carries them at fair value on the consolidated balance sheets. At both December 31, 2025 and 2024, less than 1% of debt securities were valued using inputs that reflect the Company's assumptions (categorized as Level 3 inputs in accordance with GAAP). See Note 5 ''Fair Value'' included in Item 8 of this 10-K for additional information on the methodologies and key assumptions used to determine the fair value of investments. For additional information related to investments, see Note 4 ''Investments'' included in Item 8 of this 10-K.

The Company regularly reviews debt securities in its portfolio to determine whether a decline in fair value below the cost basis or carrying value has occurred. If a debt security is in an unrealized loss position and the Company has the intent to sell the security, or it is more likely than not that the Company will have to sell the security before recovery of its amortized cost basis, the amortized cost basis of the security is written down to its fair value and the difference is recognized in net income. If a debt security is in an unrealized loss position and the Company does not have the intent to sell and it is more likely than not that the Company will not have to sell such security before recovery of its amortized cost basis, the Company bifurcates the impairment into credit-related and non-credit related components. The amount of the credit-related component is recorded as an allowance for credit losses and recognized in net income, and the amount of the non-credit related component is included in other

comprehensive income. The impairment of debt securities is considered a critical accounting policy. See ‘‘Critical Accounting Policies - Impairments of Debt Securities” in the MD&A included in Item 7 of this 10-K for additional information.

Evaluation of Market Valuation Risks

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

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

Assuming an immediate increase of 100 basis points in interest rates, the theoretical decline in the fair values of market sensitive instruments at December 31, 2025 is as follows:

- The fair value of long-term debt issued by the Company would decline by approximately $3.6 billion ($4.6 billion pretax). Changes in the fair value of long-term debt do not impact the Company’s operating results or financial condition.
- The theoretical reduction in the fair value of interest rate sensitive investments partially offset by the theoretical reduction in the fair value of interest rate sensitive liabilities would result in a net decline in fair value of approximately $765 million ($970 million pretax) related to continuing non-experience-rated products. Net reductions in fair value would be reflected as an unrealized loss in equity, as the Company classifies these debt securities as available for sale, and the effect of the interest rate on interest rate sensitive liabilities is recorded in other comprehensive income.

Based on overall exposure to interest rate risk and equity price risk, the Company believes that these changes in market rates and prices would not materially affect consolidated near-term financial condition, operating results or cash flows as of December 31, 2025.

Evaluation of Foreign Currency and Commodity Risk

At December 31, 2025 and 2024, the Company did not have any material foreign currency exchange rate or commodity derivative instruments in place and believes its exposure to foreign currency exchange rate risk is not material.

Evaluation of Operational Risks

The Company also faces certain operational risks. Those risks include risks related to information security, including cybersecurity.

The Company and its vendors have experienced diverse cyberattacks and expect to continue to experience cyberattacks going forward. As examples, the Company and its vendors have experienced attempts to gain access to systems, denial of service attacks, attempted malware infections, account takeovers, scanning activity and phishing emails. Attacks can originate from external criminals, terrorists, nation states or internal actors. The Company is dedicating and will continue to dedicate significant resources and incur significant expenses to maintain and update on an ongoing basis the systems and processes that are designed to mitigate the information security risks it faces and protect the security of its computer systems, software, networks and other technology assets against attempts by unauthorized parties to obtain access to confidential information, disrupt or degrade service or cause other damage. The impact of cyberattacks has not been material to the Company’s operations or operating results through December 31, 2025. The Board and its Audit Committee are regularly informed regarding the Company’s information security policies, practices and status. Please see “Cybersecurity” included in Item 1C of this 10-K for further information.

Item 8. Financial Statements and Supplementary Data.

Index to Consolidated Financial Statements

Consolidated Statements of Operations

In millions, except per share amounts	For the Years Ended December 31, 2025	2024	2023
Revenues:			
Products	$ 249,908	$ 231,521	$ 245,138
Premiums	134,751	122,896	99,192
Services	15,175	16,239	12,293
Net investment income	2,233	2,153	1,153
Total revenues	402,067	372,809	357,776
Operating costs:			
Cost of products sold	221,167	206,287	217,098
Health care costs	125,538	115,121	86,247
Operating expenses	44,977	41,706	39,832
Goodwill impairment	5,725	—	—
Restructuring charges	—	1,179	507
Loss on assets held for sale	—	—	349
Total operating costs	397,407	364,293	344,033
Operating income	4,660	8,516	13,743
Interest expense	(3,119)	(2,958)	(2,658)
Gain on early extinguishment of debt	—	491	—
Gain on deconsolidation of subsidiary	483	—	—
Other income	112	99	88
Income before income tax provision	2,136	6,148	11,173
Income tax provision	408	1,562	2,805
Net income	1,728	4,586	8,368
Net (income) loss attributable to noncontrolling interests	40	28	(24)
Net income attributable to CVS Health	$ 1,768	$ 4,614	$ 8,344
Net income per share attributable to CVS Health:			
Basic	$ 1.40	$ 3.67	$ 6.49
Diluted	$ 1.39	$ 3.66	$ 6.47
Weighted average shares outstanding:			
Basic	1,267	1,259	1,285
Diluted	1,271	1,262	1,290

See accompanying notes to consolidated financial statements.

Consolidated Statements of Comprehensive Income

In millions	For the Years Ended December 31, 2025	2024	2023
Net income	$ 1,728	$ 4,586	$ 8,368
Other comprehensive income (loss), net of tax:			
Net unrealized investment gains	605	30	1,090
Change in discount rate on long-duration insurance reserves	(50)	113	(67)
Foreign currency translation adjustments	11	(4)	—
Net cash flow hedges	(13)	(15)	5
Pension and other postretirement benefits	(27)	53	(61)
Other comprehensive income	526	177	967
Comprehensive income	2,254	4,763	9,335
Comprehensive (income) loss attributable to noncontrolling interests	40	28	(24)
Comprehensive income attributable to CVS Health	$ 2,294	$ 4,791	$ 9,311

See accompanying notes to consolidated financial statements.

Consolidated Balance Sheets

In millions, except per share amounts	At December 31, 2025	2024
Assets:		
Cash and cash equivalents	$ 8,453	$ 8,586
Investments	2,145	2,407
Accounts receivable, net	39,779	36,469
Inventories	19,246	18,107
Other current assets	5,091	3,076
Total current assets	74,714	68,645
Long-term investments	32,669	28,934
Property and equipment, net	13,083	12,993
Operating lease right-of-use assets	14,973	15,944
Goodwill	85,478	91,272
Intangible assets, net	25,508	27,323
Separate accounts assets	1,994	3,311
Other assets	5,119	4,793
Total assets	$ 253,538	$ 253,215
Liabilities:		
Accounts payable	$ 17,641	$ 15,892
Pharmacy claims and discounts payable	26,344	24,166
Health care costs payable	15,399	15,064
Accrued expenses and other current liabilities	22,387	20,810
Other insurance liabilities	1,116	1,183
Current portion of operating lease liabilities	1,737	1,751
Short-term debt	—	2,119
Current portion of long-term debt	4,068	3,624
Total current liabilities	88,692	84,609
Long-term operating lease liabilities	13,643	14,899
Long-term debt	60,502	60,527
Deferred income taxes	3,832	3,806
Separate accounts liabilities	1,994	3,311
Other long-term insurance liabilities	4,716	4,902
Other long-term liabilities	4,777	5,431
Total liabilities	178,156	177,485
Commitments and contingencies (Note 18)		
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; 1,787 shares issued and 1,271 shares outstanding at December 31, 2025 and 1,778 shares issued and 1,260 shares outstanding at December 31, 2024 and capital surplus	50,402	49,661
Treasury stock, at cost: 516 and 518 shares at December 31, 2025 and 2024	(36,790)	(36,818)
Retained earnings	61,196	62,837
Accumulated other comprehensive income (loss)	406	(120)
Total CVS Health shareholders' equity	75,214	75,560
Noncontrolling interests	168	170
Total shareholders' equity	75,382	75,730
Total liabilities and shareholders' equity	$ 253,538	$ 253,215

See accompanying notes to consolidated financial statements.

Consolidated Statements of Cash Flows

In millions	For the Years Ended December 31, 2025	2024	2023
Cash flows from operating activities:			
Cash receipts from customers	$ 389,128	$ 357,995	$ 345,464
Cash paid for inventory, prescriptions dispensed and health services rendered	(216,493)	(197,726)	(208,848)
Insurance benefits paid	(121,238)	(109,464)	(84,097)
Cash paid to other suppliers and employees	(37,570)	(38,821)	(34,735)
Interest and investment income received	1,969	1,735	1,584
Interest paid	(2,991)	(2,909)	(2,418)
Income taxes paid	(2,166)	(1,703)	(3,524)
Net cash provided by operating activities	10,639	9,107	13,426
Cash flows from investing activities:			
Proceeds from sales and maturities of investments	12,383	10,353	7,729
Purchases of investments	(15,012)	(15,191)	(9,043)
Purchases of property and equipment	(2,832)	(2,781)	(3,031)
Acquisitions (net of cash and restricted cash acquired)	(436)	(95)	(16,612)
Other	26	101	68
Net cash used in investing activities	(5,871)	(7,613)	(20,889)
Cash flows from financing activities:			
Commercial paper borrowings (repayments), net	(2,119)	1,919	200
Proceeds from issuance of short-term loan	—	—	5,000
Repayment of short-term loan	—	—	(5,000)
Proceeds from issuance of long-term debt	3,969	7,913	10,898
Repayments of long-term debt	(3,629)	(4,773)	(3,166)
Repurchase of common stock	—	(3,023)	(2,012)
Dividends paid	(3,397)	(3,373)	(3,132)
Proceeds from exercise of stock options	394	361	277
Payments for taxes related to net share settlement of equity awards	(158)	(185)	(181)
Other	—	26	(201)
Net cash provided by (used in) financing activities	(4,940)	(1,135)	2,683
Net increase (decrease) in cash, cash equivalents and restricted cash	(172)	359	(4,780)
Cash, cash equivalents and restricted cash at the beginning of the period	8,884	8,525	13,305
Cash, cash equivalents and restricted cash at the end of the period	$ 8,712	$ 8,884	$ 8,525

In millions	For the Years Ended December 31, 2025	2024	2023
Reconciliation of net income to net cash provided by operating activities:			
Net income	$ 1,728	$ 4,586	$ 8,368
Adjustments required to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	4,606	4,597	4,366
Goodwill impairment	5,725	—	—
Loss on assets held for sale	—	—	349
Stock-based compensation	535	540	588
Loss on sale of subsidiary	236	—	—
Gain on early extinguishment of debt	—	(491)	—
Gain on deconsolidation of subsidiary	(483)	—	—
Restructuring charges (impairment of long-lived assets)	—	840	152
Deferred income taxes	102	(572)	(676)
Other items	(336)	(502)	264
Change in operating assets and liabilities, net of effects from acquisitions:			
Accounts receivable, net	(3,498)	(1,301)	(6,260)
Inventories	(1,267)	(102)	1,233
Other assets	(2,593)	(38)	(510)
Accounts payable and pharmacy claims and discounts payable	3,855	2,335	3,618
Health care costs payable and other insurance liabilities	16	2,757	394
Other liabilities	2,013	(3,542)	1,540
Net cash provided by operating activities	$ 10,639	$ 9,107	$ 13,426

See accompanying notes to consolidated financial statements.

Consolidated Statements of Shareholders' Equity

	Number of shares outstanding		Attributable to CVS Health						
In millions	**Common Shares**	**Treasury Shares [1]**	**Common Stock and Capital Surplus [2]**	**Treasury Stock [1]**	**Retained Earnings**	**Accumulated Other Comprehensive Income (Loss)**	**Total CVS Health Shareholders' Equity**	**Noncontrolling Interests**	**Total Shareholders' Equity**
Balance at December 31, 2022	**1,758**	**(458)**	**$ 48,193**	**$ (31,858)**	**$ 56,398**	**$ (1,264)**	**$ 71,469**	**$ 300**	**$ 71,769**
Net income	—	—	—	—	8,344	—	8,344	24	8,368
Other comprehensive income (Note 15)	—	—	—	—	—	967	967	—	967
Stock option activity, stock awards and other	10	—	795	—	—	—	795	—	795
Purchase of treasury shares, net of ESPP issuances	—	(22)	(12)	(1,980)	—	—	(1,992)	—	(1,992)
Common stock dividends ($2.42 per share)	—	—	—	—	(3,138)	—	(3,138)	—	(3,138)
Acquisition of noncontrolling interests	—	—	—	—	—	—	—	66	66
Other increases (decreases) in noncontrolling interests	—	—	16	—	—	—	16	(215)	(199)
Balance at December 31, 2023	1,768	(480)	48,992	(33,838)	61,604	(297)	76,461	175	76,636
Net income	—	—	—	—	4,614	—	4,614	(28)	4,586
Other comprehensive income (Note 15)	—	—	—	—	—	177	177	—	177
Stock option activity, stock awards and other	10	—	700	—	—	—	700	—	700
Purchase of treasury shares, net of ESPP issuances	—	(38)	(22)	(2,980)	—	—	(3,002)	—	(3,002)
Common stock dividends ($2.66 per share)	—	—	—	—	(3,381)	—	(3,381)	—	(3,381)
Other increases (decreases) in noncontrolling interests	—	—	(9)	—	—	—	(9)	23	14
Balance at December 31, 2024	1,778	(518)	49,661	(36,818)	62,837	(120)	75,560	170	75,730
Net income	—	—	—	—	1,768	—	1,768	(40)	1,728
Other comprehensive income (Note 15)	—	—	—	—	—	526	526	—	526
Stock option activity, stock awards and other	9	—	741	—	—	—	741	—	741
ESPP issuances, net of purchase of treasury shares	—	2	—	28	—	—	28	—	28
Common stock dividends ($2.66 per share)	—	—	—	—	(3,409)	—	(3,409)	—	(3,409)
Other increases in noncontrolling interests	—	—	—	—	—	—	—	38	38
Balance at December 31, 2025	**1,787**	**(516)**	**$ 50,402**	**$ (36,790)**	**$ 61,196**	**$ 406**	**$ 75,214**	**$ 168**	**$ 75,382**

(1) Treasury shares include 1 million shares held in trust for each of the years ended December 31, 2025, 2024 and 2023. Treasury stock includes $29 million related to shares held in trust for each of the years ended December 31, 2025, 2024 and 2023. See Note 1 ''Significant Accounting Policies'' for additional information.

(2) Common stock and capital surplus includes the par value of common stock of $18 million as of December 31, 2025, 2024 and 2023.

See accompanying notes to consolidated financial statements.

Notes to Consolidated Financial Statements

1. Significant Accounting Policies

Description of Business

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health" or the "Company"), 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, 2025, the Company had approximately 9,000 retail locations, more than 1,000 walk-in and primary care medical clinics and a leading pharmacy benefits manager with approximately 87 million plan members and expanding specialty pharmacy solutions. The Company also serves an estimated more than 37 million people through traditional, voluntary and consumer-directed health insurance products and related services, including expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). The Company is creating new sources of value through its integrated model allowing it 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.

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

Health Care Benefits Segment
The Health Care Benefits segment operates as one of the nation's leading diversified health care benefits providers through its Aetna® operations. 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 primary customers, its members, primarily access the segment's products and services through employer groups, government-sponsored plans or individually. The Health Care Benefits segment also serves customers who purchase products and services that are ancillary to its health insurance products. The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk for medical and dental care costs) as "ASC." The Company also sold Insured plans directly to individual consumers through the individual public health insurance exchanges ("Public Exchanges") through the year ended December 31, 2025. The Company exited the states in which Aetna operated on the Public Exchanges effective January 2026.

Health Services Segment
The Health Services segment provides a full range of pharmacy benefit management ("PBM") solutions through its CVS Caremark® operations and delivers health care services in its medical clinics, virtually, and in the home. 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. The segment also works directly with pharmaceutical manufacturers to commercialize and/or co-produce high quality biosimilar products through its Cordavis™ subsidiary. The Health Services segment's health care delivery assets include Signify Health, Inc. ("Signify Health"), a leader in health risk assessments and value-based care, and Oak Street Health, Inc. ("Oak Street Health"), a leading multi-payor operator of value-based primary care centers serving Medicare eligible patients. The Health Services segment's clients and customers are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Medicaid managed care plans, the U.S. Centers for Medicare & Medicaid Services ("CMS"), plans offered on public and private health 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.

Pharmacy & Consumer Wellness Segment
The Pharmacy & Consumer Wellness segment dispenses prescriptions in its CVS Pharmacy® retail locations and through its infusion operations, provides ancillary pharmacy services including pharmacy patient care programs and vaccination administration, and sells a wide assortment of health and wellness products and general merchandise. The segment also provides pharmacy fulfillment services to support the Health Services segment's specialty and mail order pharmacy offerings. As of December 31, 2025, the Pharmacy & Consumer Wellness segment operated approximately 9,000 retail locations, as well

as online retail pharmacy websites, retail specialty pharmacy stores, compounding pharmacies and branches for infusion and enteral nutrition services.

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

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

Basis of Presentation

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

Use of Estimates

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

Cash and Cash Equivalents

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

Restricted Cash

Restricted cash included in other current assets on the consolidated balance sheets primarily represents funds held on behalf of members. Restricted cash included in other assets on the consolidated balance sheets represents amounts held in a trust in one of the Company's captive insurance companies to satisfy collateral requirements associated with the assignment of certain insurance policies. All restricted cash is invested in demand deposits, time deposits and money market funds.

The following is a reconciliation of cash and cash equivalents on the consolidated balance sheets to total cash, cash equivalents and restricted cash on the consolidated statements of cash flows as of December 31, 2025, 2024 and 2023:

In millions	**2025**	**2024**	**2023**
Cash and cash equivalents	$ 8,453	$ 8,586	$ 8,196
Restricted cash (included in other current assets)	59	95	90
Restricted cash (included in other assets)	200	203	239
Total cash, cash equivalents and restricted cash in the consolidated statements of cash flows	$ 8,712	$ 8,884	$ 8,525

Investments

Debt Securities
Debt securities consist primarily of U.S. Treasury and agency securities, mortgage-backed securities, corporate and foreign bonds and other debt securities. Debt securities are classified as either current or long-term investments based on their contractual maturities unless the Company intends to sell an investment within the next twelve months, in which case it is classified as current on the consolidated balance sheets. Debt securities are classified as available for sale and are carried at fair value. See Note 5 ''Fair Value'' for additional information on how the Company estimates the fair value of these investments.

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

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

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

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

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

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

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

Other Investments
Other investments consist primarily of the following:

- Private equity and hedge fund limited partnerships, which are accounted for using the equity method of accounting. Under this method, the carrying value of the investment is based on the value of the Company's equity ownership of the underlying investment funds provided by the general partner or manager of the investments, the financial statements of which generally are audited. As a result of the timing of the receipt of the valuation information provided by the fund

managers, these investments are generally reported on up to a three month lag. The Company reviews investments for impairment at least quarterly and monitors their performance throughout the year through discussions with the administrators, managers and/or general partners. If the Company becomes aware of an impairment of a limited partnership's investments through its review or prior to receiving the limited partnership's financial statements at the financial statement date, an impairment will be recognized by recording a reduction in the carrying value of the limited partnership with a corresponding charge to net investment income.

- Investment real estate, which is carried on the consolidated balance sheets at depreciated cost, including capital additions, net of write-downs for other-than-temporary declines in fair value. Depreciation is calculated using the straight-line method based on the estimated useful life of each asset. If any real estate investment is considered held-for-sale, it is carried at the lower of its carrying value or fair value less estimated selling costs. The Company generally estimates fair value using net operating income and applying a capitalization rate in conjunction with comparable sales information. At the time of the sale, the difference between the sales price and the carrying value is recorded as a realized capital gain or loss.
- Privately-placed equity securities, which are carried on the consolidated balance sheets using the measurement alternative, at cost less impairments, plus or minus subsequent adjustments for observable price changes.

Net Investment Income

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

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

Realized capital gains and losses on investments supporting large case pensions' experience-rated products are not included in realized capital gains and losses in the consolidated statements of operations and instead are credited directly to contract holders' accounts. The contract holders' accounts are reflected in accrued expenses and other current liabilities 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 (loss). Unrealized capital gains and losses on investments supporting large case pensions' experience-rated products are credited directly to contract holders' accounts. The contract holders' accounts are reflected in accrued expenses and other current liabilities on the consolidated balance sheets.

Derivative Financial Instruments

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

Accounts Receivable

Accounts receivable are stated net of allowances for credit losses, customer credit allowances, contractual allowances and estimated terminations. Accounts receivable, net was composed of the following at December 31, 2025 and 2024:

In millions	**2025**	**2024**
Trade receivables	$ 10,563	$ 9,881
Vendor and manufacturer receivables	15,564	13,891
Premium receivables	5,753	4,731
Other receivables	7,899	7,966
Total accounts receivable, net	$ 39,779	$ 36,469

The Company's allowance for credit losses was $182 million and $407 million as of December 31, 2025 and 2024, respectively. When developing an estimate of the Company's expected credit losses, the Company considers all available relevant information regarding the collectability of cash flows, including historical information, current conditions and reasonable and supportable forecasts of future economic conditions over the contractual life of the receivable. The Company's accounts receivable are short duration in nature and typically settle in less than 30 days.

Inventories

Inventories are valued at the lower of cost or net realizable value using the weighted average cost method. Physical inventory counts are taken on a regular basis in each retail store and pharmacy, and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the consolidated financial statements are properly stated. During the interim period between physical inventory counts, the Company accrues for anticipated physical inventory losses on a location-by-location basis based on historical results and current physical inventory trends.

Reinsurance Recoverables

The Company utilizes reinsurance agreements primarily to: (a) reduce required capital and (b) facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit the Company to recover a portion of its losses from reinsurers, although they do not discharge the Company's primary liability as the direct insurer of the risks reinsured. Failure of reinsurers to indemnify the Company could result in losses; however, the Company does not expect charges for unrecoverable reinsurance to have a material effect on its consolidated operating results or financial condition. The Company evaluates the financial condition of its reinsurers and monitors concentrations of credit risk arising from similar geographic regions, activities or economic characteristics of its reinsurers. At December 31, 2025, the Company's reinsurance recoverables consisted primarily of amounts due from third parties that are rated consistent with companies that are considered to have the ability to meet their obligations. Reinsurance recoverables are recorded as other current assets or other assets on the consolidated balance sheets.

Health Care Contract Acquisition Costs

Insurance products included in the Health Care Benefits segment are cancellable by either the customer or the member monthly upon written notice. Acquisition costs related to prepaid health care and health indemnity contracts are generally expensed as incurred. For certain long-duration insurance contracts, acquisition costs directly related to the successful acquisition of a new or renewal insurance contract, including commissions, are deferred and are recorded as other current assets or other assets on the consolidated balance sheets. Contracts are grouped by product and issue year into cohorts consistent with the grouping used in estimating the associated liability and are amortized on a constant level basis based on the remaining in-force policies over the estimated term of the contracts to approximate straight-line amortization. Changes to the Company's assumptions, including assumptions related to persistency, are reflected at the cohort level at the time of change and are recognized prospectively over the estimated terms of the contract. The amortization of deferred acquisition costs is recorded in operating expenses in the consolidated statements of operations.

The following is a roll forward of deferred acquisition costs for the years ended December 31, 2025 and 2024:

In millions	**2025**	**2024**
Deferred acquisition costs, beginning of the period	$ 1,747	$ 1,502
Capitalizations	516	544
Amortization expense	(346)	(299)
Deferred acquisition costs, end of the period	$ 1,917	$ 1,747

Property and Equipment

Property and equipment is reported at historical cost, net of accumulated depreciation. Property, equipment and improvements to leased premises are depreciated using the straight-line method over the estimated useful lives of the assets, or when applicable, the term of the lease, whichever is shorter. Estimated useful lives generally range from 1 to 40 years for buildings, building improvements and leasehold improvements and 3 to 10 years for fixtures, equipment and internally developed software. Repair and maintenance costs are charged directly to expense as incurred. Major renewals or replacements that substantially extend the useful life of an asset are capitalized and depreciated. Application development stage costs for significant internally developed software projects are capitalized and depreciated.

Property and equipment consisted of the following at December 31, 2025 and 2024:

In millions	**2025**	**2024**
Land	$ 1,809	$ 1,847
Building and improvements	4,593	4,632
Fixtures and equipment	11,737	11,716
Leasehold improvements	6,812	6,725
Software	12,876	11,520
Total property and equipment	37,827	36,440
Accumulated depreciation and amortization	(24,744)	(23,447)
Property and equipment, net	$ 13,083	$ 12,993

Depreciation expense (which includes the amortization of property and equipment under finance leases) totaled $2.6 billion, $2.6 billion and $2.5 billion for the years ended December 31, 2025, 2024 and 2023, respectively. See Note 7 ‘‘Leases’’ for additional information about the Company’s finance leases.

Right-of-Use Assets and Lease Liabilities

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

The Company’s real estate leases typically contain options that permit renewals for additional periods of up to five years each. For real estate leases, the options to extend are not considered reasonably certain at lease commencement because the Company reevaluates each lease on a regular basis to consider the economic and strategic incentives of exercising the renewal options and regularly opens or closes stores to align with its operating strategy. Generally, the renewal option periods are not included within the lease term and the associated payments are not included in the measurement of the right-of-use asset and lease liability. Similarly, renewal options are not included in the lease term for non-real estate leases because they are not considered reasonably certain of being exercised at lease commencement. Leases with an initial term of 12 months or less are not recorded on the balance sheets, and lease expense is recognized on a straight-line basis over the term of the short-term lease.

For real estate leases, the Company accounts for lease components and nonlease components as a single lease component. Certain real estate leases require additional payments based on sales volume, as well as reimbursement for real estate taxes, common area maintenance and insurance, which are expensed as incurred as variable lease costs. Other real estate leases

contain one fixed lease payment that includes real estate taxes, common area maintenance and insurance. These fixed payments are considered part of the lease payment and included in the right-of-use assets and lease liabilities.

See Note 7 ‘‘Leases’’ for additional information about right-of-use assets and lease liabilities.

Goodwill

The Company accounts for business combinations using the acquisition method of accounting, which requires the excess cost of an acquisition over the fair value of net assets acquired and identifiable intangible assets to be recorded as goodwill. Goodwill is not amortized, but is subject to impairment reviews annually, or more frequently, if necessary, as further described in “Recoverability of Long-Lived Assets” below.

See Note 6 ‘‘Goodwill and Other Intangibles’’ for additional information about goodwill.

Intangible Assets

The Company’s identifiable intangible assets consist primarily of trademarks, trade names, customer contracts/relationships, covenants not to compete, technology and provider networks. These intangible assets arise primarily from the determination of their respective fair market values at the date of acquisition. Amounts assigned to identifiable intangible assets, and their related useful lives, are derived from established valuation techniques and management estimates.

The Company’s definite-lived intangible assets are amortized over their estimated useful lives based upon the pattern of future cash flows attributable to the asset. Definite-lived intangible assets are amortized using the straight-line method. Indefinite-lived intangible assets are not amortized but are tested for impairment annually, or more frequently, if necessary, as further described in “Recoverability of Long-Lived Assets” below.

See Note 6 ‘‘Goodwill and Other Intangibles’’ for additional information about intangible assets.

Recoverability of Long-Lived Assets

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

During the year ended December 31, 2024, in connection with its enterprise-wide restructuring plan described in Note 3 ‘‘Restructuring’’, the Company recorded a store impairment charge of $607 million, consisting of a write down of $483 million related to lease right-of-use assets and $124 million related to property and equipment. In addition, the Company conducted a review of its various strategic assets and determined that it would discontinue the use of certain non-core assets, in connection with which it recorded $269 million of other asset impairments and related charges as reductions to property and equipment, net and operating lease right-of-use assets. During the year ended December 31, 2023, in connection with its 2023 restructuring program, the Company recorded $152 million of asset impairment charges in connection with the termination of certain transformation initiatives.

See Note 3 ‘‘Restructuring’’ for additional information about the Company’s restructuring plan.

The Company continuously evaluates its corporate office real estate space in response to its ongoing flexible work arrangement and changes in employee work arrangement requirements to ensure it has the appropriate space to support the business. As a result of its assessment, the Company determined that it would vacate and abandon certain leased corporate office spaces. During the years ended December 31, 2025, 2024 and 2023, the Company recorded $10 million, $30 million, and $46 million, respectively, of office real estate optimization charges primarily related to operating lease right-of-use assets and property and equipment. The office real estate optimization charges were recorded in operating expenses within each segment.

See Note 7 ‘‘Leases’’ for additional information about the right-of-use asset charges.

When evaluating goodwill for potential impairment, the Company compares the fair value of its reporting units to their respective carrying amounts. The Company estimates the fair value of its reporting units using a combination of a discounted cash flow method and a market multiple method. If the carrying amount of a reporting unit exceeds its estimated fair value, an impairment loss is recognized in an amount equal to that excess.

During the fourth quarter of 2025, the Company performed its required annual impairment test of goodwill and concluded there were no goodwill impairments as of the testing date. During the third quarter of 2025, the Company performed an interim goodwill impairment test of the Health Care Delivery reporting unit after determining there were indicators that the Health Care Delivery’s reporting unit’s goodwill may be impaired. The results of the interim impairment test showed that the fair value of the Health Care Delivery reporting unit was lower than its carrying value, resulting in a $5.7 billion goodwill impairment charge recorded during the third quarter of 2025.

See Note 6 ‘‘Goodwill and Other Intangibles’’ for additional information about the Health Care Delivery reporting unit goodwill impairment.

During the fourth quarter of 2024, the Company performed its required annual impairment test of goodwill and concluded there were no goodwill impairments as of the testing date. During the third quarter of 2024, the Company performed an interim goodwill impairment test of the Government reporting unit after determining there were indicators that the Government reporting unit’s goodwill may be impaired. The results of the interim impairment test showed that the fair value of the Government reporting unit exceeded its carrying value, therefore there was no impairment of goodwill as of the interim testing date.

During the fourth quarter of 2023, the Company performed its required annual impairment test of goodwill and concluded there were no goodwill impairments as of the testing date or during the year ended December 31, 2023.

Indefinite-lived intangible assets are tested for impairment by comparing the estimated fair value of the asset to its carrying value. The Company estimates the fair value of its indefinite-lived trademarks using the relief from royalty method under the income approach. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized, and the asset is written down to its estimated fair value. There were no impairment losses recognized on indefinite-lived intangible assets in the years ended December 31, 2025, 2024 or 2023.

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 within the Health Care Benefits segment consist principally of unpaid fee-for-service medical, dental and pharmacy claims, capitation costs, other amounts due to providers pursuant to risk-sharing arrangements related to the Health Care Benefits segment’s Insured Commercial, Medicare and Medicaid products and accruals for state assessments. Unpaid health care claims include an estimate of payments the Company will make for (i) services rendered to the Company’s Insured members but not yet reported to the Company and (ii) claims which have been reported to the Company but not yet paid, each as of the financial statement date (collectively, “IBNR”). Health care costs payable also include an estimate of the cost of services that will continue to be rendered after the financial statement date if the Company is obligated to pay for such services in accordance with contractual or regulatory requirements. Such estimates are developed using actuarial principles and assumptions which consider, among other things, historical and projected claim submission and processing patterns, assumed and historical medical cost trends, historical utilization of medical services, claim inventory levels, changes in Insured membership and product mix, seasonality and other relevant factors. The Company reflects changes in these estimates in benefit costs in the Company’s consolidated operating results in the period they are determined. Capitation costs represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the volume

of medical services provided to the Insured member. Amounts due under risk-sharing arrangements are based on the terms of the underlying contracts with the providers and consider claims experience under the contracts through the financial statement date. Within the Health Services segment, health care costs payable includes estimates of the Company's obligations for medical care services that have been rendered by third parties on behalf of consumers for which the Company is contractually obligated to pay, but for which claims have either not yet been received, processed or paid.

The Company develops its estimate of IBNR using actuarial principles and assumptions that consider numerous factors. Of those factors, the Company considers the analysis of historical and projected claim payment patterns (including claims submission and processing patterns) and the assumed health care cost trend rate (the year-over-year change in per member per month health care costs) to be the most critical assumptions. In developing its IBNR estimate, the Company consistently applies these actuarial principles and assumptions each period, with consideration to the variability of related factors. There have been no significant changes to the methodologies or assumptions used to develop the Company's estimate of IBNR in 2025.

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, 2025; 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, 2025 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 health care 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 8 ''Health Care Costs Payable.'' The Company's reserving practice is to consistently recognize the actuarial best estimate of its ultimate liability for health care costs payable.

Other Insurance Liabilities

Unpaid Claims
Unpaid claims consist primarily of reserves associated with certain short-duration group disability and term life insurance contracts, including an estimate for IBNR as of the financial statement date. Reserves associated with certain short-duration group disability and term life insurance contracts are based upon the Company's estimate of the present value of future benefits, which is based on assumed investment yields and assumptions regarding mortality, morbidity and recoveries from the U.S. Social Security Administration. The Company develops its estimate of IBNR using actuarial principles and assumptions which consider, among other things, contractual requirements, claim incidence rates, claim recovery rates, seasonality and other relevant factors. The Company discounts certain claim liabilities related to group long-term disability and life insurance waiver of premium contracts. The discount rates generally reflect the Company's expected investment returns for the investments supporting all incurral years of these liabilities. The discount rates for retrospectively-rated contracts are set at contractually specified levels. The Company's estimates of unpaid claims are subject to change due to changes in the underlying experience of the insurance contracts, changes in investment yields or other factors, and these changes are recorded in current and future benefits in the consolidated statements of operations in the period they are determined. The Company estimates its reserve for claims IBNR for life products largely based on completion factors. The completion factors used are based on the Company's historical experience and reflect judgments and possible adjustments based on data such as claim inventory levels, claim payment patterns, changes in business volume and other factors. If claims are submitted or processed on a faster (slower) pace than historical periods, the actual claims may be more (less) complete than originally estimated using completion factors, which may result in reserves that are higher (lower) than required to cover future life benefit payments. There have been no significant changes to the methodologies or assumptions used to develop the Company's estimate of unpaid claims IBNR in 2025. As of December 31, 2025, unpaid claims balances of $202 million and $599 million were recorded in other insurance liabilities and other long-term insurance liabilities, respectively. As of December 31, 2024, unpaid claims balances of $280 million and $713 million 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 products for which the Company no longer solicits or accepts new customers, including limited payment pension and annuity contracts and long-term care insurance contracts. Contracts are grouped into cohorts by contract type and issue year. The liability for future policy benefits is adjusted for differences between actual and expected experience.

Reserves for limited payment pension and annuity contracts represent the Company's estimate of the present value of future benefits to be paid to or on behalf of policyholders and are computed using actuarial principles that consider, among other things, assumptions reflecting anticipated mortality and retirement experience. On an annual basis, or more frequently if necessary, the Company reviews mortality assumptions against both industry standards and its experience.

Reserves for long-term care insurance contracts represent the Company's estimate of the present value of future benefits and settlement costs to be paid to or on behalf of policyholders less the present value of future net premiums. The Company's estimate of the present value of future benefits under such contracts is based upon mortality, morbidity, lapse and interest rate assumptions. On an annual basis, or more frequently if necessary, the Company reviews its mortality, morbidity and lapse assumptions against its experience. Annually, or each time the assumptions are changed, the net premium ratio used to calculate the future policy benefit liability is updated to reflect actual experience, as well as the impact of any change in assumptions on the Company's future cash flows.

The Company discounts its future policy benefit liability using a curve of spot rates derived from Single A rated fixed income instruments. At each reporting date, the Company will measure its liability for future policy benefits using both the current spot

rate curve and the locked-in discount rate at each cohort's inception. Any difference between the measured liabilities is recorded in other comprehensive income.

As of December 31, 2025, future policy benefits balances of $360 million and $4.1 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively. As of December 31, 2024, future policy benefits balances of $371 million and $4.2 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively.

Premium Deficiency Reserves

The Company evaluates its short-duration insurance contracts to determine if it is probable that a loss will be incurred. 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. For each contract grouping, a premium deficiency reserve is recognized when it is probable that expected future incurred claims, including costs to maintain the contract grouping exceed anticipated future premiums and reinsurance recoveries. Anticipated investment income is not considered in the calculation of premium deficiency reserves. A premium deficiency is first recognized by charging any unamortized acquisition costs to operating expenses, and to the extent the premium deficiency is greater than the unamortized acquisition costs, a premium deficiency reserve liability is established and reflected in health care costs payable on the consolidated balance sheets. Losses recognized as a premium deficiency reserve result in a beneficial effect in subsequent periods as subsequent costs under these contracts are then charged to this previously established liability.

2025 Activity
During the first quarter of 2025, the Company determined it had a premium deficiency in its individual exchange product line related to the remainder of the 2025 coverage year and, accordingly, recorded a premium deficiency reserve of $448 million. The premium deficiency reserve consisted of a $17 million write-off of unamortized acquisition costs, which was recorded in operating expenses, and $431 million recorded in health care costs which was subsequently utilized throughout the remainder of 2025. The Company did not have any premium deficiency reserves related to its individual exchange product line as of December 31, 2025.

Additionally, during the second quarter of 2025, the Company recorded a premium deficiency reserve of $471 million to health care costs related to its Group Medicare Advantage product line for the remainder of the 2025 coverage year, which was subsequently utilized throughout the remainder of 2025. The Company did not have any premium deficiency reserves related to its Group Medicare Advantage product line as of December 31, 2025.

2024 Activity
During the third quarter of 2024, the Company determined it had a premium deficiency in its Medicare product line related to the remainder of the 2024 coverage year and, accordingly, recorded a premium deficiency reserve of $766 million. The premium deficiency reserve consisted of a $383 million write-off of unamortized acquisition costs, which was recorded in operating expenses, and $383 million recorded in health care costs which was subsequently utilized in the fourth quarter of 2024. The Company did not have any premium deficiency reserves related to its Medicare product line as of December 31, 2024.

Additionally, during the third quarter of 2024, the Company recorded a premium deficiency reserve of $270 million related to its individual exchange product line for the remainder of the 2024 coverage year. The premium deficiency reserve consisted of an $11 million write-off of unamortized acquisition costs, which was recorded in operating expenses, and $259 million recorded in health care costs which was subsequently utilized in the fourth quarter of 2024. The Company did not have any premium deficiency reserves related to its individual exchange product line as of December 31, 2024.

The Company did not have any other premium deficiency reserves as of December 31, 2025 or 2024.

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. As of December 31, 2025 and 2024, self-insurance liabilities totaled $1.2 billion and $1.1 billion, respectively, and were recorded in accrued expenses and other current liabilities, as well as other long-term liabilities on the consolidated balance sheets.

Foreign Currency Translation and Transactions

For non-U.S. dollar functional currency locations, (i) assets and liabilities are translated at end-of-period exchange rates, (ii) revenues and expenses are translated at average exchange rates in effect during the period and (iii) equity is translated at historical exchange rates. The resulting cumulative translation adjustments are included as a component of accumulated other comprehensive income (loss).

For U.S. dollar functional currency locations, foreign currency assets and liabilities are remeasured into U.S. dollars at end-of-period exchange rates, except for nonmonetary balance sheet accounts which are remeasured at historical exchange rates. Revenues and expenses are remeasured at average exchange rates in effect during each period, except for those expenses related to the nonmonetary balance sheet amounts which are remeasured at historical exchange rates. Gains or losses from foreign currency remeasurement are included in net income.

Gains and losses from foreign currency transactions and the effects of foreign currency remeasurements were not material in the years ended December 31, 2025, 2024 or 2023.

Revenue Recognition

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

The Company's billings may be subsequently adjusted to reflect enrollment changes due to member terminations or other factors. These adjustments are known as retroactivity adjustments. In each period, the Company estimates the amount of future retroactivity and adjusts the recorded revenue accordingly. As information regarding actual retroactivity amounts becomes known, the Company refines its estimates and records any required adjustments to revenues in the period in which they arise.

Premium Revenue
Premiums are recognized as revenue in the month in which the enrollee is entitled to receive health care services. Premiums are reported net of an allowance for estimated terminations and uncollectible amounts. Additionally, premium revenue subject to the minimum medical loss ratio ("MLR") rebate requirements of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (as amended, collectively, the "ACA") is recorded net of the estimated minimum MLR rebates for the current calendar year. Premiums related to unexpired contractual coverage periods (unearned premiums) are reported as other insurance liabilities on the consolidated balance sheets and recognized as revenue when earned.

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

The ACA established a permanent risk adjustment program to transfer funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of the Company's qualified plan members relative to the average risk of members of other qualified plans in comparable markets, as defined by the ACA, the Company estimates its ultimate risk adjustment receivable (recorded in accounts receivable) or payable (recorded in accrued expenses and other current liabilities) for the current calendar year and reflects the pro-rata year-to-date impact as an adjustment to premium revenue.

Services Revenue
Services revenue relates to contracts that can include various combinations of services or series of services which generally are capable of being distinct and accounted for as separate performance obligations. The Health Care Benefits segment's services revenue primarily consists of ASC fees received in exchange for performing certain claim processing and member services for ASC members. ASC fee revenue is recognized over the period the service is provided. Some of the Company's administrative services contracts include guarantees with respect to certain functions, such as customer service response time, claim processing accuracy and claim processing turnaround time, as well as certain guarantees that a plan sponsor's benefit claim experience will

fall within a certain range. With any of these guarantees, the Company is financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk typically is limited to a percentage of the fees otherwise payable to the Company by the customer involved. Each period the Company estimates its obligations under the terms of these guarantees and records its estimate as an offset to services revenues.

Accounting for Medicare Part D

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

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

In addition to Medicare Part D premiums, the Company receives additional payments each month from CMS related to catastrophic reinsurance, low-income cost-sharing subsidies and the manufacturer discount program. 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.

Health Services Segment

Pharmacy Services

The Health Services segment sells prescription drugs directly through its specialty and mail order pharmacy offerings 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 fulfillment 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 fulfilled indirectly through its retail pharmacy network because it has separate contractual arrangements with those pharmacies, has discretion in setting the price for the transaction and assumes primary responsibility for fulfilling the promise to provide prescription drugs to its client plan members while also performing the related PBM services.

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

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

- Revenues generated from prescription drugs sold by third party pharmacies in the Company's retail pharmacy network and associated administrative fees are recognized at the Company's point-of-sale, which is when the claim is adjudicated by the Company's online claims processing system and the Company has transferred control of the prescription drug and completed all of its performance obligations.
- Revenues generated from prescription drugs sold by specialty and mail order 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.

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

Drug Discounts

The Company records revenue net of manufacturers' rebates earned by its clients based on their plan members' utilization of brand-name formulary drugs. The Company estimates these rebates at period-end based on actual and estimated claims data and its estimates of the manufacturers' rebates earned by its clients. The estimates are based on the best available data at period-end and recent history for the various factors that can affect the amount of rebates due to the client. The Company adjusts its rebates payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. Any cumulative effect of these adjustments is recorded against revenues at the time it is identified. Adjustments generally result from contract changes with clients or manufacturers that have retroactive rebate adjustments, differences between the estimated and actual product mix subject to rebates, or whether the brand name drug was included in the applicable formulary. The effect of adjustments between estimated and actual manufacturers' rebate amounts has not been material to the Company's operating results or financial condition.

Guarantees

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

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.

Primary Care Capitated Revenue

Capitated revenue related to the Company's primary care operations consists primarily of capitated fees for medical services it provides under capitated or capitation arrangements directly made with various Medicare Advantage managed care payors or CMS. Under the risk contracts, the Company receives from the third-party payor a fixed payment per patient per month for a defined patient population, and the Company is then responsible for providing, managing and paying for healthcare services for that patient population, including those not provided by the Company. The Company recognizes revenue using the gross method as the Company is the principal in arranging, providing and controlling the managed healthcare services provided to the defined patient population. The Company considers all contracts with customers (enrolled patients) as a single performance obligation to stand ready to provide healthcare services. This performance obligation is satisfied over time as the Company stands ready to fulfill its obligation to enrolled patients.

In-Home Health Evaluations ("IHEs")

Revenue generated from IHEs relates to the assessments performed either within the patient's home, virtually or at a healthcare provider facility as well as certain in-home clinical evaluations performed by the Company's mobile network of providers. Revenue is recognized when the IHEs are submitted to customers on a daily basis. Submission to the customer occurs after the IHEs are completed and coded, a process which may take one to several days after completion of the evaluation. The pricing for the IHEs is generally based on a fixed transaction fee, which is directly linked to the usage of the service by the customer during a distinct service period. Customers are invoiced for evaluations performed each month and remit payment accordingly. Each IHE represents a single performance obligation for which revenue is recognized at a point in time when control is transferred to the customer upon submission of the completed and coded evaluation.

Pharmacy & Consumer Wellness Segment

Retail Pharmacy

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

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

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

Loyalty and Other Programs

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

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

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

Disaggregation of Revenue

The following table disaggregates the Company's revenue by major source in each segment for the years ended December 31, 2025, 2024 and 2023:

In millions	**Health Care Benefits**	**Health Services**	**Pharmacy & Consumer Wellness**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
2025						
Major goods/services lines:						
Pharmacy	$ —	$ 181,109	$ 115,510	$ —	$ (67,594)	$ 229,025
Front Store	—	—	21,459	—	—	21,459
Premiums	134,749	—	—	45	(43)	134,751
Net investment income	1,782	20	—	431	—	2,233
Other	6,823	9,296	2,398	8	(3,926)	14,599
Total	$ 143,354	$ 190,425	$ 139,367	$ 484	$ (71,563)	$ 402,067
Health Services distribution channel:						
Pharmacy network [1]		$ 101,775				
Mail & specialty [2]		79,334				
Net investment income		20				
Other		9,296				
Total		$ 190,425				
2024						
Major goods/services lines:						
Pharmacy	$ —	$ 162,527	$ 100,687	$ —	$ (52,942)	$ 210,272
Front Store	—	—	21,522	—	—	21,522
Premiums	122,849	—	—	47	—	122,896
Net investment income	1,473	285	—	395	—	2,153
Other	6,343	10,793	2,291	9	(3,470)	15,966
Total	$ 130,665	$ 173,605	$ 124,500	$ 451	$ (56,412)	$ 372,809
Health Services distribution channel:						
Pharmacy network [1]		$ 91,650				
Mail & specialty [2]		70,877				
Net investment income		285				
Other		10,793				
Total		$ 173,605				

In millions	Health Care Benefits	Health Services	Pharmacy & Consumer Wellness	Corporate/ Other	Intersegment Eliminations	Consolidated Totals
2023						
Major goods/services lines:						
Pharmacy	$ —	$ 180,710	$ 92,111	$ —	$ (49,369)	$ 223,452
Front Store	—	—	22,458	—	—	22,458
Premiums	99,144	—	—	48	—	99,192
Net investment income (loss)	765	(1)	(5)	394	—	1,153
Other	5,737	6,134	2,199	9	(2,558)	11,521
Total	$ 105,646	$ 186,843	$ 116,763	$ 451	$ (51,927)	$ 357,776
Health Services distribution channel:						
Pharmacy network [1]		$ 112,718				
Mail & specialty [2]		67,992				
Net investment income (loss)		(1)				
Other		6,134				
Total		$ 186,843				

(1) Health Services pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including pharmacies owned by the Company, as well as activity associated with Maintenance Choice®, 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) Health Services mail & specialty is defined as specialty mail claims inclusive of Specialty Connect® claims picked up at a retail pharmacy, as well as mail order and specialty claims fulfilled by the Pharmacy & Consumer Wellness segment.

Contract Balances

Contract liabilities primarily represent the Company's obligation to transfer additional goods or services to a customer for which the Company has received consideration, and primarily include ExtraBucks Rewards and unredeemed Company gift cards. The consideration received remains a contract liability until goods or services have been provided to the customer. In addition, the Company recognizes breakage on Company gift cards based on historical redemption patterns.

The following table provides information about receivables and contract liabilities from contracts with customers as of December 31, 2025 and 2024:

In millions	2025	2024
Trade receivables (included in accounts receivable, net)	$ 10,563	$ 9,881
Contract liabilities (included in accrued expenses and other current liabilities)	62	144

Cost of Products Sold

The Company accounts for cost of products sold as follows:

Health Services Segment

Cost of products sold includes: (i) the cost of prescription drugs sold during the reporting period directly through the Company's specialty and mail order pharmacies and indirectly through the Company's retail pharmacy network, (ii) the cost of care provided within the Company's primary care centers, (iii) direct operating costs associated with generating revenues related to services provided, including fees paid to clinicians for performing IHEs, (iv) administrative service fees paid to the Pharmacy & Consumer Wellness segment for specialty and mail order pharmacy fulfillment services and (v) shipping and handling costs.

The cost of prescription drugs sold component of cost of products sold includes: (i) the cost of the prescription drugs purchased from manufacturers or distributors and shipped to members in clients' benefit plans from the Company's mail order pharmacies, net of any volume-related or other discounts (see "Vendor Allowances and Purchase Discounts" below) and (ii) the cost of prescription drugs sold (including retail co-payments) through the Company's retail pharmacy network under contracts where the Company is the principal, net of any volume-related or other discounts.

The cost of care provided within the Company's costs of products sold includes the costs incurred to operate the primary care centers and care model. These costs consist of care team and patient support employee-related costs, occupancy costs, patient transportation, medical supplies, insurance, fees paid to specialists and other operating costs.

Pharmacy & Consumer Wellness Segment
Cost of products sold includes: the cost of merchandise sold during the reporting period, including the costs of prescription drugs sold through its retail pharmacies, net of any volume-related or other discounts, the related purchasing costs, warehousing and delivery costs (including depreciation and amortization), the operating costs of the Company's specialty and mail order pharmacy fulfillment operations and inventory losses.

Vendor Allowances and Purchase Discounts

The Company accounts for vendor allowances and purchase discounts as follows:

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

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

Advertising Costs

Advertising costs, which are reduced by the portion funded by vendors, are expensed when the related advertising takes place. Net advertising costs, which are included in operating expenses, were $970 million, $989 million and $985 million in the years ended December 31, 2025, 2024 and 2023, respectively.

Stock-Based Compensation

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as expense over the requisite service period of the stock award (generally three to five years) using the straight-line method.

Income Taxes

The Company accounts for income taxes under the asset and liability method, which requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of events that have been included in the consolidated financial

statements. Under this method, deferred tax assets and liabilities are determined on the basis of the differences between the consolidated financial statements and tax basis of assets and liabilities using enacted tax rates in effect for the year or years in which the differences are expected to reverse. The effect of a change in the tax rates on deferred tax assets and liabilities is recognized in income in the period that includes the enactment date of such change.

The Company recognizes deferred tax assets to the extent that it believes these assets are more likely than not to be realized. In making such a determination, the Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax planning strategies, and the Company's recent operating results. The Company establishes a valuation allowance when it does not consider it more likely than not that a deferred tax asset will be recovered.

The Company records uncertain tax positions on the basis of a two-step process whereby (1) the Company determines whether it is more likely than not that the tax positions will be sustained on the basis of the technical merits of the position and (2) for those tax positions that meet the more-likely-than-not recognition threshold, the Company recognizes the largest amount of tax benefit that is more than 50% likely to be realized upon ultimate settlement with the related tax authority.

Interest and/or penalties related to uncertain tax positions are recognized in the income tax provision.

Measurement of Defined Benefit Pension and Other Postretirement Employee Benefit Plans

The Company sponsors defined benefit pension plans ("pension plans") and other postretirement employee benefit plans ("OPEB plans") for its employees and retirees. The Company recognizes the funded status of its pension and OPEB plans on the consolidated balance sheets based on the year-end measurements of plan assets and benefit obligations. When the fair value of plan assets are in excess of the plan benefit obligations, the amounts are reported in other current assets and other assets. When the fair value of plan benefit obligations are in excess of plan assets, the amounts are reported in accrued expenses and other current liabilities and other long-term liabilities based on the amount by which the actuarial present value of benefits payable in the next twelve months included in the benefit obligation exceeds the fair value of plan assets. The net periodic benefit income for the Company's pension and OPEB plans do not contain a service cost component as these plans have been frozen for an extended period of time. Non-service cost components of pension and postretirement net periodic benefit income are included in other income in the consolidated statements of operations.

Earnings per Share

Earnings per share is computed using the treasury stock method. The Company calculates basic earnings per share based on the weighted average number of common shares outstanding for the period. See Note 16 ''Earnings Per Share'' for additional information.

Shares Held in Trust

The Company maintains grantor trusts, which held approximately 1 million shares of its common stock at both December 31, 2025 and 2024. 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.

VIEs

The Company has various investments that are considered VIEs. The Company does not have a future obligation to fund losses or debts on behalf of these investments; however, it may voluntarily contribute funds. In evaluating whether the Company is the primary beneficiary of a VIE, the Company considers several factors, including whether the Company has (a) the power to direct the activities that most significantly impact the VIE's economic performance and (b) the obligation to absorb losses and the right to receive benefits that could potentially be significant to the VIE.

VIEs - Primary Beneficiary

Red Oak Sourcing, LLC ("Red Oak")
In 2014, the Company and Cardinal Health, Inc. ("Cardinal") established Red Oak, a generic pharmaceutical sourcing entity in which the Company and Cardinal each own 50%. The Red Oak arrangement had an initial term of ten years. In 2021, the Red Oak arrangement was amended to extend the initial term an additional five years, for a total term of 15 years. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source

and negotiate generic pharmaceutical supply contracts for both companies through Red Oak; however, Red Oak does not own or hold inventory on behalf of either company. No physical assets (e.g., property and equipment) were contributed to Red Oak by either company, and minimal funding was provided to capitalize Red Oak. The Company has determined that it is the primary beneficiary of this VIE because it has the ability to direct the activities of Red Oak. Consequently, the Company consolidates Red Oak in its consolidated financial statements within the Pharmacy & Consumer Wellness segment.

Cardinal is required to pay the Company quarterly payments, which began in October 2014 and will extend through June 2029. The Company received $80 million, $126 million and $183 million from Cardinal during the years ended December 31, 2025, 2024 and 2023, respectively. The payments reduce the Company's carrying value of inventory and are recognized in cost of products sold when the related inventory is sold.

Physician Groups

The Company has entered into management and/or administrative services agreements with affiliated physician practice organizations (the "Physician Groups"). Physician Groups employ healthcare providers, contract with managed care payors and deliver healthcare services to patients in the markets that the Company serves. Oak Street Health, MSO LLC ("OSH MSO"), a wholly-owned subsidiary of the Company, provides management services to the Physician Groups. Activities include but are not limited to operational support of the centers, marketing, information technology infrastructure and the sourcing and managing of health plan contracts. The Company concluded that it has variable interests in the Physician Groups on the basis of its administrative service agreement, which includes the reimbursement of costs and a management fee payable to the Company from the Physician Groups for the management services provided, which are eliminated in consolidation. The Physician Groups are considered VIEs as additional support is needed to finance their operations. Neither shareholders, employees nor their designees have the individual power to direct the activities of the Physician Groups that significantly impact its economic performance. The success or failure of OSH MSO in performing the activities impacting the growth of patients and management of healthcare services of the Physicians Groups' patient base is significant to the economic performance of the Physician Groups. Therefore, the Company is the primary beneficiary of the Physician Groups and, consequently, consolidates the Physician Groups in its consolidated financial statements within the Health Services segment.

Physician Groups VIE assets and liabilities included on the consolidated balance sheet at December 31, 2025 and 2024 were as follows:

In millions	**2025**	**2024**
Total assets	$ 2,975	$ 2,144
Total liabilities	3,170	2,104

There are no restrictions on the Physician Groups' assets or on the settlement of its liabilities. The assets of the Physician Groups are all current and can be used to settle obligations of the Company. The Physician Groups are included in the Company's obligated group; thus, creditors of the Company have recourse to the assets owned by the Physician Groups. There are no liabilities for which creditors of the Physician Groups do not have recourse to the general credit of the Company. There are no restrictions placed on the retained earnings or net income of the Physician Groups with respect to potential dividend payments.

Physician Owned Entities

The Company's consolidated VIEs include certain IHE related physician practices that require an individual physician to legally own the equity interests as certain state laws and regulations prohibit non-physician owned business entities from practicing medicine or employing licensed healthcare providers. The Company determined it was the primary beneficiary of these VIEs as it has the obligation to absorb the losses from and direct the activities of these operations. As a result, these VIEs are consolidated and any noncontrolling interest is not presented. The carrying amount of these VIEs' assets and liabilities are not material to the consolidated balance sheets.

VIEs - Other Variable Interest Holder

The Company has invested in certain VIEs for which it has determined that it is not the primary beneficiary, consisting of the following:

- *Hedge fund and private equity investments* - The Company invests in hedge fund and private equity investments in order to generate investment returns for its investment portfolio supporting its insurance businesses.

- *Real estate partnerships* - The Company invests in various real estate partnerships, including those that construct, own and manage low-income housing developments. For the low-income housing development investments, substantially all of the projected benefits to the Company are from tax credits and other tax benefits.

The Company is not the primary beneficiary of these VIEs because the nature of the Company's involvement with the activities of these VIEs does not give the Company the power to direct the activities that most significantly impact their economic performance. The Company records the amount of its investment in these VIEs as long-term investments on the consolidated balance sheets and recognizes its share of each VIE's income or losses in net income. 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.

Other variable interest holder VIE assets included in long-term investments on the consolidated balance sheets at December 31, 2025 and 2024 were as follows:

In millions	**2025**	**2024**
Hedge fund investments	$ 1,684	$ 1,246
Private equity investments	905	934
Real estate partnerships	580	438
Total	$ 3,169	$ 2,618

Subsidiary Bankruptcy

On September 22, 2025, Omnicare, LLC ("Omnicare"), a wholly-owned indirect subsidiary of CVS Health Corporation, and certain of Omnicare's subsidiary entities (collectively, the "Omnicare Entities") voluntarily initiated Chapter 11 proceedings under the U.S. Bankruptcy Code. As a result of the initiation of Chapter 11 proceedings, the Company determined that it no longer retained control of the Omnicare Entities and deconsolidated the subsidiaries on September 22, 2025. The Omnicare Entities conduct long-term care pharmacy ("LTC") operations, which distribute prescription drugs and provide related pharmacy consulting and ancillary services to long-term care facilities and other care settings. Prior to deconsolidation, the financial results of the Omnicare Entities were not material and were included in the Pharmacy & Consumer Wellness segment. As a result of the deconsolidation, the Company recorded a gain on deconsolidation of subsidiary of $483 million. Subsequent to deconsolidation, the Company's retained investment related to its equity ownership of the Omnicare Entities had both a carrying value and a fair value of $0.

Related Party Transactions

During the year ended December 31, 2025, the Company made a charitable contribution of $50 million to the CVS Health Foundation, a non-profit entity that focuses on health, education and community involvement programs. The charitable contribution was recorded as an operating expense within the Corporate/Other segment for the year ended December 31, 2025. The Company did not make any charitable contributions to the CVS Health Foundation during the years ended December 31, 2024 or 2023.

Discontinued Operations

In connection with certain business dispositions completed between 1995 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Linens 'n Things, which subsequently filed for bankruptcy. The Company's loss from discontinued operations includes lease-related costs that the Company believes it will likely be required to satisfy pursuant to these lease guarantees. See "Lease Guarantees" in Note 18 ''Commitments and Contingencies'' for additional information.

Results from discontinued operations were immaterial for the years ended December 31, 2025, 2024 and 2023.

New Accounting Pronouncements Recently Adopted

Segment Reporting
In November 2023, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2023-07, *Segment Reporting (Topic 280): Improvements to Reportable Segment Disclosures*. This standard requires the Company to disclose significant segment expenses that are regularly provided to the Chief Operating Decision Maker

("CODM") and are included within each reported measure of segment operating results. The standard also requires the Company to disclose the total amount of any other items included in segment operating results which were not deemed to be significant expenses for separate disclosure, along with a qualitative description of the composition of these other items. In addition, the standard also requires disclosure of the CODM's title and position, as well as detail on how the CODM uses the reported measure of segment operating results to evaluate segment performance and allocate resources. The standard also aligns interim segment reporting disclosure requirements with annual segment reporting disclosure requirements. The Company adopted the standard on January 1, 2024 for fiscal year reporting and the standard became effective for interim reporting periods in fiscal years beginning after December 15, 2024. The standard requires retrospective application to all prior periods presented. While the standard requires additional disclosures related to the Company's reportable segments, the standard did not have any impact on the Company's consolidated operating results, financial condition or cash flows as of the date of adoption. Refer to Note 19 ''Segment Reporting'' for the Company's segment reporting disclosures, including those newly required by this standard.

Income Taxes
In December 2023, the FASB issued ASU 2023-09, *Income Taxes (Topic 740): Improvements to Income Tax Disclosures*. The standard requires the Company to provide further disaggregated income tax disclosures for specific categories on the effective tax rate reconciliation, as well as additional information about federal, state/local and foreign income taxes. The standard also requires the Company to annually disclose its income taxes paid (net of refunds received), disaggregated by jurisdiction. The Company adopted the standard on a retrospective basis on January 1, 2025 for fiscal year reporting. While the standard requires additional disclosures related to the Company's income taxes, the standard did not have any impact on the Company's consolidated operating results, financial condition or cash flows.

New Accounting Pronouncements Not Yet Adopted

Disaggregation of Income Statement Expenses
In November 2024, the FASB issued ASU 2024-03, *Income Statement—Reporting Comprehensive Income—Expense Disaggregation Disclosures (Subtopic 220-40): Disaggregation of Income Statement Expenses*. The standard requires the Company to provide further disaggregated information of relevant expense captions within its consolidated statements of operations, including the purchases of inventory, employee compensation, depreciation and intangible asset amortization, as well as the inclusion of other specific expenses, gains and losses required by existing GAAP. The new standard also requires the Company to disclose its total selling expenses and, on an annual basis, provide a qualitative description of its selling expenses. The standard is effective for fiscal years beginning after December 15, 2026 and interim periods within fiscal years beginning after December 15, 2027, with early adoption permitted. The standard may be applied prospectively or retrospectively. While the standard will require additional disclosures related to certain expenses included in the consolidated statements of operations, the standard is not expected to have any impact on the Company's consolidated operating results, financial condition or cash flows.

Internal-Use Software
In September 2025, the FASB issued ASU 2025-06, *Targeted Improvements to the Accounting for Internal-Use Software*. This standard is intended to modernize the accounting for internal-use software. Under the new standard, the Company will capitalize eligible costs when (i) management has authorized and committed to funding the software project, and (ii) it is probable that the project will be completed and the software will be used to perform the function intended. The standard is effective for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2027, with early adoption permitted as of the beginning of a fiscal year. The standard may be applied prospectively, retrospectively or using a modified transition approach. The Company is currently evaluating the impact that this standard will have on the Company's consolidated operating results, cash flows, financial condition and related disclosures.

2. Acquisition and Divestiture

Rite Aid Asset Acquisition

In May 2025, the Company reached an agreement to acquire the prescription files of certain Rite Aid pharmacies, as well as acquire and operate certain Rite Aid stores in Idaho, Oregon and Washington for total consideration of $465 million. The closings were completed during the third quarter of 2025. The Company recorded $285 million of customer relationships intangible assets related to the prescription file acquisitions, which will be amortized over a weighted average period of 10 years.

ACO REACH and MSSP Exit

Prior to the first quarter of 2025, the Company's Health Services segment provided enablement services to health systems primarily through two programs administered by CMS: the Accountable Care Organization Realizing Equity, Access and Community Health ("ACO REACH") program and the Medicare Shared Savings Program ("MSSP"). During the first quarter of 2025, the Company determined that it would substantially exit both the ACO REACH program and the MSSP as further described below. In connection with these actions, during the year ended December 31, 2025, the Company recorded expenses of $288 million, which were included in the loss on Accountable Care assets and are reflected in operating expenses within the Health Services segment.

ACO REACH
In February 2025, the Company informed CMS of its plans to voluntarily terminate substantially all of its participation in the ACO REACH program effective March 31, 2025. In connection with the process of winding down its ACO REACH operations, the Company incurred costs of $52 million during the year ended December 31, 2025.

MSSP
In March 2025, the Company also divested its MSSP operations to Wellvana Health, LLC. The Company recorded a pre-tax loss on the divestiture of $236 million in the year ended December 31, 2025, which includes the removal of intangible assets and goodwill totaling $342 million. The consideration received related to this agreement was not material.

3. Restructuring

2024 Restructuring Program

During the third quarter of 2024, the Company finalized an enterprise-wide restructuring plan intended to streamline and simplify the organization, improve efficiency and reduce costs to partially offset the expected return of certain variable expenses in 2025. In connection with this restructuring plan, during 2024, the Company recorded pre-tax restructuring charges of approximately $1.2 billion, comprised of a $607 million store impairment charge, $293 million of costs associated with corporate workforce optimization, including severance and employee-related costs, a $10 million stock-based compensation charge associated with the impacted employees, which was reflected as an adjustment to common stock and capital surplus on the consolidated balance sheets, and $269 million of other asset impairments and related charges associated with the discontinuation of certain non-core assets.

Store impairment charge
The Company evaluates its retail store right-of-use and property and equipment assets for impairment at the retail store level, which is the lowest level at which cash flows can be identified. For retail stores where there is an indicator of impairment present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted). If the estimated undiscounted future cash flows used in the analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to its estimated fair value which is the greater of the asset group's estimated future cash flows (discounted), or the consideration of what a market participant would pay to lease the assets, net of leasing costs. The Company's estimate of fair value considers historical results, current operating trends, consolidated sales, profitability and cash flow results and forecasts. For assets which the Company has determined it will be able to sublease, the estimated future cash flows include the estimated sublease income, net of estimated leasing costs. When the carrying value of an asset group exceeds its estimated fair value, an impairment loss is recorded to reduce the value of the asset group to its estimated fair value. As the impaired assets are measured at fair value on a nonrecurring basis primarily using unobservable inputs as of the measurement date, the assets are classified in Level 3 of the fair value hierarchy.

During the third quarter of 2024, in connection with its enterprise-wide restructuring plan, the Company completed a strategic review of its retail business, which included evaluating changes in population, consumer buying patterns and future health requirements to ensure continued alignment of its retail footprint with consumer needs. In connection with this initiative the Company determined it planned to close additional retail stores in 2025. As a result, management determined that there were indicators of impairment with respect to the impacted stores' asset groups, including the associated operating or financing lease right-of-use assets and property and equipment.

A long-lived asset impairment test was performed during the third quarter of 2024, the results of which indicated that the fair value of certain retail store asset groups was lower than their respective carrying values. Accordingly, at that time, the Company recorded a store impairment charge of $607 million, consisting of a write down of $483 million related to operating and

financing lease right-of-use assets and $124 million related to property and equipment. The charge associated with the store impairments was included in the restructuring charges within the Pharmacy & Consumer Wellness segment. Subsequent to the impairment loss, the fair value of the associated operating and financing lease right-of-use assets and property and equipment were $100 million and $39 million, respectively.

Corporate workforce optimization costs
Corporate workforce optimization costs, including severance and employee-related costs, consist primarily of salary continuation benefits, prorated annual incentive compensation, continuation of health care benefits and outplacement services. Severance and employee-related benefits are determined pursuant to the Company's written severance plans and are recognized when the benefits are determined to be probable of being paid and are reasonably estimable.

In connection with its enterprise-wide restructuring plan, the Company recorded corporate workforce optimization costs of $293 million, which were recorded in accrued expenses and other current liabilities on the consolidated balance sheet. The restructuring charge associated with the corporate workforce optimization costs was reflected within the Corporate/Other segment. The Company made payments of $193 million and $88 million related to severance and employee-related costs associated with the 2024 restructuring program during the years ended December 31, 2025 and 2024, respectively. As of December 31, 2025, the 2024 restructuring program was substantially complete.

Other asset impairment charges
In connection with its enterprise-wide restructuring plan, the Company also conducted a review of its various strategic assets and determined that it would discontinue the use of certain non-core assets, including certain virtual care services and compounding infusion pharmacies and branches. As a result, management determined that there were indicators of impairment with respect to the impacted long-lived assets and a long-lived asset impairment test was performed during the third quarter of 2024. The results of the long-lived asset impairment test indicated that the respective fair values of certain impacted assets were lower than their respective carrying values and, accordingly, the Company recorded $269 million of other asset impairments and related charges associated with the discontinuation of these assets. The asset impairment charges were recorded as reductions to property and equipment, net and operating lease right-of-use assets on the consolidated balance sheet. The other asset impairment charges were included in the restructuring charges within the Corporate/ Other and Pharmacy & Consumer Wellness segments. Subsequent to the impairment charges, the fair value of the associated long-lived assets was not material.

2023 Restructuring Program

During the second quarter of 2023, the Company developed an enterprise-wide restructuring plan intended to streamline and simplify the organization, improve efficiency and reduce costs. In connection with the development of this plan and the completed acquisitions of Signify Health and Oak Street Health, the Company also conducted a strategic review of its various transformation initiatives and determined that it would terminate certain initiatives. In connection with the restructuring plan, during 2023, the Company recorded $507 million in pre-tax restructuring charges, comprised of $344 million of severance and employee-related costs associated with corporate workforce optimization, $152 million of asset impairment charges and an $11 million stock-based compensation charge associated with the impacted employees. These restructuring charges are reflected in the Corporate/Other segment. The severance and employee-related costs were recorded in accrued expenses and other current liabilities and the asset impairments were recorded as a reduction of property and equipment, net, while the stock-based compensation charge was reflected as an adjustment to common stock and capital surplus on the consolidated balance sheet.

Severance and employee-related costs consist primarily of salary continuation benefits, prorated annual incentive compensation, continuation of health care benefits and outplacement services. Severance and employee-related benefits are determined pursuant to the Company's written severance plans and are recognized when the benefits are determined to be probable of being paid and are reasonably estimable. During the year ended December 31, 2023, the Company made payments of $194 million related to severance and employee-related costs associated with the 2023 restructuring program. During the year ended December 31, 2024, substantially all of the remaining liabilities were paid. The Company did not have any remaining liability related to the 2023 restructuring program as of December 31, 2025.

4. Investments

Total investments at December 31, 2025 and 2024 were as follows:

	2025			2024		
In millions	**Current**	**Long-term**	**Total**	**Current**	**Long-term**	**Total**
Debt securities available for sale	$ 1,997	$ 26,721	$ 28,718	$ 2,256	$ 23,777	$ 26,033
Mortgage loans	148	1,376	1,524	151	1,354	1,505
Other investments	—	4,572	4,572	—	3,803	3,803
Total investments	$ 2,145	$ 32,669	$ 34,814	$ 2,407	$ 28,934	$ 31,341

Debt Securities

Debt securities available for sale at December 31, 2025 and 2024 were as follows:

In millions	**Amortized Cost [1]**	**Gross Unrealized Gains**	**Gross Unrealized Losses**	**Fair Value**
December 31, 2025				
Debt securities:				
U.S. government securities	$ 2,691	$ 39	$ (8)	$ 2,722
States, municipalities and political subdivisions	296	3	(7)	292
U.S. corporate securities	14,657	262	(231)	14,688
Foreign securities	2,981	78	(31)	3,028
Residential mortgage-backed securities	1,065	14	(29)	1,050
Commercial mortgage-backed securities	1,974	28	(23)	1,979
Other asset-backed securities	4,921	25	(2)	4,944
Redeemable preferred securities	15	—	—	15
Total debt securities [2]	$ 28,600	$ 449	$ (331)	$ 28,718
December 31, 2024				
Debt securities:				
U.S. government securities	$ 2,826	$ 7	$ (38)	$ 2,795
States, municipalities and political subdivisions	712	4	(18)	698
U.S. corporate securities	13,043	94	(412)	12,725
Foreign securities	2,608	27	(111)	2,524
Residential mortgage-backed securities	792	2	(54)	740
Commercial mortgage-backed securities	1,731	9	(67)	1,673
Other asset-backed securities	4,834	35	(7)	4,862
Redeemable preferred securities	16	—	—	16
Total debt securities [2]	$ 26,562	$ 178	$ (707)	$ 26,033

(1) There was no allowance for expected credit losses recorded on available-for-sale debt securities at December 31, 2025 or December 31, 2024.

(2) Investment risks associated with the Company's experience-rated products generally do not impact the Company's consolidated operating results. At December 31, 2025, debt securities with a fair value of $475 million, gross unrealized capital gains of $10 million and gross unrealized capital losses of $16 million, and at December 31, 2024, debt securities with a fair value of $543 million, gross unrealized capital gains of $5 million and gross unrealized capital losses of $30 million were included in total debt securities, but support experience-rated products. Changes in net unrealized capital gains (losses) on these securities are not reflected in accumulated other comprehensive income (loss).

The amortized cost and fair value of debt securities at December 31, 2025 are shown below by contractual maturity. Actual maturities may differ from contractual maturities because securities may be restructured, called or prepaid, or the Company intends to sell a security prior to maturity.

In millions	**Amortized Cost**	**Fair Value**
Due to mature:		
Less than one year	$ 815	$ 817
One year through five years	11,540	11,699
After five years through ten years	5,297	5,382
Greater than ten years	2,988	2,847
Residential mortgage-backed securities	1,065	1,050
Commercial mortgage-backed securities	1,974	1,979
Other asset-backed securities	4,921	4,944
Total	$ 28,600	$ 28,718

Mortgage-Backed and Other Asset-Backed Securities
All of the Company's residential mortgage-backed securities at December 31, 2025 were issued by the Government National Mortgage Association, the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation and carry agency guarantees and explicit or implicit guarantees by the U.S. Government. At December 31, 2025, the Company's residential mortgage-backed securities had an average credit quality rating of AA and a weighted average duration of 5.8 years.

The Company's commercial mortgage-backed securities have underlying loans that are dispersed throughout the U.S. Significant market observable inputs used to value these securities include loss severity and probability of default. At December 31, 2025, these securities had an average credit quality rating of AAA and a weighted average duration of 5.0 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, 2025, these securities had an average credit quality rating of AA and a weighted average duration of less than one year.

Summarized below are the debt securities the Company held at December 31, 2025 and 2024 that were in an unrealized capital loss position, aggregated by the length of time the investments have been in that position:

	Less than 12 months			Greater than 12 months			Total		
In millions, except number of securities	**Number of Securities**	**Fair Value**	**Unrealized Losses**	**Number of Securities**	**Fair Value**	**Unrealized Losses**	**Number of Securities**	**Fair Value**	**Unrealized Losses**
December 31, 2025									
Debt securities:									
U.S. government securities	50	$ 156	$ 2	80	$ 168	$ 6	130	$ 324	$ 8
States, municipalities and political subdivisions	16	28	—	89	136	7	105	164	7
U.S. corporate securities	1,045	1,634	23	1,541	2,149	208	2,586	3,783	231
Foreign securities	180	310	2	303	449	29	483	759	31
Residential mortgage-backed securities	67	124	1	303	272	28	370	396	29
Commercial mortgage-backed securities	84	290	1	126	269	22	210	559	23
Other asset-backed securities	136	314	1	19	27	1	155	341	2
Redeemable preferred securities	—	—	—	4	6	—	4	6	—
Total debt securities	1,578	$ 2,856	$ 30	2,465	$ 3,476	$ 301	4,043	$ 6,332	$ 331
December 31, 2024									
Debt securities:									
U.S. government securities	266	$ 1,053	$ 18	155	$ 394	$ 20	421	$ 1,447	$ 38
States, municipalities and political subdivisions	100	181	3	137	201	15	237	382	18
U.S. corporate securities	3,119	4,144	64	2,602	3,395	348	5,721	7,539	412
Foreign securities	599	810	21	616	874	90	1,215	1,684	111
Residential mortgage-backed securities	89	267	5	361	342	49	450	609	54
Commercial mortgage-backed securities	186	628	11	237	464	56	423	1,092	67
Other asset-backed securities	139	414	5	62	58	2	201	472	7
Redeemable preferred securities	4	9	—	4	6	—	8	15	—
Total debt securities	4,502	$ 7,506	$ 127	4,174	$ 5,734	$ 580	8,676	$13,240	$ 707

The Company reviewed the securities in the table above and concluded that they are performing assets generating investment income to support the needs of the Company's business. In performing this review, the Company considered factors such as the quality of the investment security based on research performed by the Company's internal credit analysts and external rating agencies and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. Unrealized capital losses at December 31, 2025 were generally caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities. As of December 31, 2025, the Company did not intend to sell these securities, and did not believe it was more likely than not that it would be required to sell these securities prior to the anticipated recovery of their amortized cost basis.

The maturity dates for debt securities in an unrealized capital loss position at December 31, 2025 were as follows:

	Supporting experience-rated products		Supporting remaining products		Total	
In millions	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
Due to mature:						
Less than one year	$ —	$ —	$ 119	$ 1	$ 119	$ 1
One year through five years	47	2	1,676	40	1,723	42
After five years through ten years	21	1	1,389	40	1,410	41
Greater than ten years	116	13	1,668	180	1,784	193
Residential mortgage-backed securities	9	—	387	29	396	29
Commercial mortgage-backed securities	5	—	554	23	559	23
Other asset-backed securities	6	—	335	2	341	2
Total	$ 204	$ 16	$ 6,128	$ 315	$ 6,332	$ 331

Mortgage Loans

The Company's mortgage loans are collateralized by commercial real estate. During the years ended December 31, 2025 and 2024, the Company had the following activity in its mortgage loan portfolio:

In millions	2025	2024
New mortgage loans	$ 221	$ 323
Mortgage loans fully repaid	160	104
Mortgage loans foreclosed	—	—

The Company assesses mortgage loans on a regular basis for credit impairments, and assigns a credit quality indicator to each loan. The Company's credit quality indicator is internally developed and categorizes each loan in its portfolio on a scale from 1 to 7. These indicators are based upon several factors, including current loan-to-value ratios, current and future property cash flow, property condition, market trends, creditworthiness of the borrower and deal structure.

- *Category 1* - Represents loans of superior quality.
- *Categories 2 to 4* - Represent loans where credit risk is minimal to acceptable; however, these loans may display some susceptibility to economic changes.
- *Categories 5 and 6* - Represent loans where credit risk is not substantial, but these loans warrant management's close attention.
- *Category 7* - Represents loans where collections are potentially at risk; if necessary, an impairment is recorded.

Based upon the Company's assessments at December 31, 2025 and 2024, the amortized cost basis of the Company's mortgage loans within each credit quality indicator by year of origination was as follows:

	Amortized Cost Basis by Year of Origination						
In millions, except credit quality indicator	**2025**	**2024**	**2023**	**2022**	**2021**	**Prior**	**Total**
December 31, 2025							
1	$ —	$ —	$ —	$ —	$ —	$ 4	$ 4
2 to 4	217	316	274	276	165	236	1,484
5 and 6	—	—	—	30	4	2	36
7	—	—	—	—	—	—	—
Total	$ 217	$ 316	$ 274	$ 306	$ 169	$ 242	$ 1,524
December 31, 2024							
1		$ —	$ —	$ —	$ —	$ 8	$ 8
2 to 4		315	292	320	205	320	1,452
5 and 6		—	—	4	13	28	45
7		—	—	—	—	—	—
Total		$ 315	$ 292	$ 324	$ 218	$ 356	$ 1,505

At December 31, 2025 scheduled mortgage loan principal repayments were as follows:

In millions	
2026	$ 148
2027	247
2028	341
2029	308
2030	141
Thereafter	339
Total	$ 1,524

Net Investment Income

Sources of net investment income for the years ended December 31, 2025, 2024 and 2023 were as follows:

In millions	**2025**	**2024**	**2023**
Debt securities	$ 1,332	$ 1,136	$ 841
Mortgage loans	86	76	59
Other investments	913	887	796
Gross investment income	2,331	2,099	1,696
Investment expenses	(54)	(63)	(46)
Net investment income (excluding net realized capital gains or losses)	2,277	2,036	1,650
Net realized capital gains (losses)	(44)	117	(497)
Net investment income	$ 2,233	$ 2,153	$ 1,153

Excluding amounts related to experience-rated products, proceeds from the sale of available-for-sale debt securities and the related gross realized capital gains and losses in the years ended December 31, 2025, 2024 and 2023 were as follows:

In millions	**2025**	**2024**	**2023**
Proceeds from sales	$ 8,587	$ 6,489	$ 5,031
Gross realized capital gains	68	37	9
Gross realized capital losses	(131)	(190)	420

5. Fair Value

The preparation of the Company's consolidated financial statements requires certain assets and liabilities to be reflected at their fair value and others to be reflected on another basis, such as an adjusted historical cost basis. In this note, the Company provides details on the fair value of financial assets and liabilities and how it determines those fair values. The Company presents this information for those financial instruments that are measured at fair value for which the change in fair value impacts net income attributable to CVS Health or other comprehensive income separately from other financial assets and liabilities.

Financial Instruments Measured at Fair Value on the Consolidated Balance Sheets

Certain of the Company's financial instruments are measured at fair value on the consolidated balance sheets. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by GAAP. The following are the levels of the hierarchy and a brief description of the type of valuation information ("valuation inputs") that qualifies a financial asset or liability for each level:

- Level 1 – Unadjusted quoted prices for identical assets or liabilities in active markets.
- Level 2 – Valuation inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, valuation inputs that are observable that are not prices (such as interest rates and credit risks) and valuation inputs that are derived from or corroborated by observable markets.
- Level 3 – Developed from unobservable data, reflecting the Company's assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, the Company uses these quoted market prices to determine the fair value of financial assets and liabilities and classifies these assets and liabilities in Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, the Company estimates fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities are classified in Level 2. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The following is a description of the valuation methodologies used for the Company's financial assets and liabilities that are measured at fair value, including the general classification of such assets and liabilities pursuant to the valuation hierarchy.

Cash and Cash Equivalents – The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. When quoted prices are available in an active market, cash equivalents are classified in Level 1 of the fair value hierarchy. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt Securities – Where quoted prices are available in an active market, debt securities are classified in Level 1 of the fair value hierarchy. The Company's Level 1 debt securities consist primarily of U.S. Treasury securities.

The fair values of the Company's Level 2 debt securities are obtained using models, such as matrix pricing, which use quoted market prices of debt securities with similar characteristics or discounted cash flows to estimate fair value. The Company reviews these prices to ensure they are based on observable market inputs that include quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets and inputs that are observable that are not prices (such as interest rates and credit risks). The Company also reviews the methodologies and the

assumptions used to calculate prices from these observable inputs. On a quarterly basis, the Company selects a sample of its Level 2 debt securities' prices and compares them to prices provided by a secondary source. Variances over a specified threshold are identified and reviewed to confirm the price provided by the primary source represents an appropriate estimate of fair value. In addition, the Company's internal investment team consistently compares the prices obtained for select Level 2 debt securities to the team's own independent estimates of fair value for those securities. The Company obtained one price for each of its Level 2 debt securities and did not adjust any of those prices at December 31, 2025 or 2024.

The Company also values certain debt securities using Level 3 inputs. For Level 3 debt securities, fair values are determined by outside brokers or, in the case of certain private placement securities, are priced internally. Outside brokers determine the value of these debt securities through a combination of their knowledge of the current pricing environment and market flows. The Company did not have any broker quoted debt securities for the years ended December 31, 2025 and 2024. For some private placement securities, the Company's internal staff determines the value of these debt securities by analyzing spreads of corporate and sector indices as well as interest spreads of comparable public bonds. Examples of these private placement Level 3 debt securities include certain U.S. and foreign securities and certain tax-exempt municipal securities.

Equity Securities – The Company currently has two classifications of equity securities: those that are publicly traded and those that are privately placed. Publicly-traded equity securities are classified in Level 1 or Level 2. Publicly-traded equity securities where quoted prices are available in an active market are classified as Level 1. The fair values of the Company's Level 2 publicly-traded equity securities are obtained using models, such as matrix pricing, which use quoted market prices of securities with similar characteristics or discounted cash flows to estimate fair value. For privately placed equity securities, there is no active market; therefore, these securities are classified in Level 3 because the Company prices these securities through an internal analysis of each investment's financial statements and cash flow projections. Significant unobservable inputs consist of earnings and revenue multiples, discount for lack of marketability and comparability adjustments. An increase or decrease in any of these unobservable inputs would have resulted in a change in the fair value measurement.

There were no financial liabilities measured at fair value on a recurring basis on the consolidated balance sheets at December 31, 2025 or 2024. Financial assets measured at fair value on a recurring basis on the consolidated balance sheets at December 31, 2025 and 2024 were as follows:

In millions	**Level 1**	**Level 2**	**Level 3**	**Total**
December 31, 2025				
Cash and cash equivalents	$ 4,030	$ 4,423	$ —	$ 8,453
Debt securities:				
U.S. government securities	2,713	9	—	2,722
States, municipalities and political subdivisions	—	292	—	292
U.S. corporate securities	—	14,682	6	14,688
Foreign securities	—	3,028	—	3,028
Residential mortgage-backed securities	—	1,050	—	1,050
Commercial mortgage-backed securities	—	1,979	—	1,979
Other asset-backed securities	—	4,944	—	4,944
Redeemable preferred securities	—	15	—	15
Total debt securities	2,713	25,999	6	28,718
Equity securities	105	30	198	333
Total	$ 6,848	$ 30,452	$ 204	$ 37,504
December 31, 2024				
Cash and cash equivalents	$ 4,948	$ 3,638	$ —	$ 8,586
Debt securities:				
U.S. government securities	2,777	18	—	2,795
States, municipalities and political subdivisions	—	698	—	698
U.S. corporate securities	—	12,687	38	12,725
Foreign securities	—	2,524	—	2,524
Residential mortgage-backed securities	—	740	—	740
Commercial mortgage-backed securities	—	1,673	—	1,673
Other asset-backed securities	—	4,862	—	4,862
Redeemable preferred securities	—	16	—	16
Total debt securities	2,777	23,218	38	26,033
Equity securities	234	—	126	360
Total	$ 7,959	$ 26,856	$ 164	$ 34,979

The changes in the balances of Level 3 financial assets during the year ended December 31, 2025 were as follows:

In millions	Commercial mortgage-backed securities	U.S. corporate securities	Equity securities	Redeemable preferred securities	Total
Beginning balance	$ —	$ 38	$ 126	$ —	$ 164
Net realized and unrealized capital gains (losses):					
Included in net income	—	7	26	—	33
Included in other comprehensive income	—	(2)	—	—	(2)
Purchases	19	40	52	23	134
Sales	—	(33)	(6)	—	(39)
Transfers out of Level 3, net	(19)	(44)	—	(23)	(86)
Ending balance	$ —	$ 6	$ 198	$ —	$ 204

During the year ended December 31, 2025, there was no change in net unrealized capital losses included in other comprehensive income associated with Level 3 financial assets which were held as of December 31, 2025.

The changes in the balances of Level 3 financial assets during the year ended December 31, 2024 were as follows:

In millions	Commercial mortgage-backed securities	U.S. corporate securities	Other asset-backed securities	Equity securities	Total
Beginning balance	$ —	$ 29	$ —	$ 79	$ 108
Net realized and unrealized capital gains (losses):					
Included in net income	—	(5)	—	28	23
Included in other comprehensive income	—	(1)	—	—	(1)
Purchases	52	15	15	19	101
Sales	—	—	—	—	—
Transfers out of Level 3, net	(52)	—	(15)	—	(67)
Ending balance	$ —	$ 38	$ —	$ 126	$ 164

The change in net unrealized capital losses included in other comprehensive income associated with Level 3 financial assets which were held as of December 31, 2024 was $1 million during the year ended December 31, 2024.

The total gross transfers into (out of) Level 3 during the years ended December 31, 2025 and 2024 were as follows:

In millions	2025	2024
Gross transfers into Level 3	$ —	$ —
Gross transfers out of Level 3	(86)	(67)
Net transfers out of Level 3	$ (86)	$ (67)

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, 2025 and 2024 were as follows:

	Carrying	Estimated Fair Value			
In millions	**Value**	**Level 1**	**Level 2**	**Level 3**	**Total**
December 31, 2025					
Assets:					
Mortgage loans	$ 1,524	$ —	$ —	$ 1,524	$ 1,524
Equity securities [1]	555	N/A	N/A	N/A	N/A
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	1	—	—	1	1
Without a fixed maturity	270	—	—	251	251
Long-term debt	64,570	62,321	—	—	62,321
December 31, 2024					
Assets:					
Mortgage loans	$ 1,505	$ —	$ —	$ 1,468	$ 1,468
Equity securities [1]	490	N/A	N/A	N/A	N/A
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	1	—	—	1	1
Without a fixed maturity	312	—	—	272	272
Long-term debt	64,151	58,724	—	—	58,724

(1) It was not practical to estimate the fair value of these investments as it represents shares of unlisted companies. See Note 1 ‘‘Significant Accounting Policies’’ for additional information regarding the valuation of investments accounted for under the measurement alternative method.

Separate Accounts Measured at Fair Value on the Consolidated Balance Sheets

Separate Accounts assets relate to the Company’s large case pensions products which represent funds maintained to meet specific objectives of contract holders. Since contract holders bear the investment risk of these assets, a corresponding Separate Accounts liability has been established equal to the assets. These assets and liabilities are carried at fair value. Net investment income and capital gains and losses on Separate Accounts assets accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from the Company’s other businesses. Deposits, withdrawals, net investment income and realized and unrealized capital gains and losses on Separate Accounts assets are not reflected in the consolidated statements of operations, shareholders’ equity or cash flows.

Separate Accounts assets include debt and equity securities. The valuation methodologies used for these assets are similar to the methodologies described above in this Note 5 ‘‘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, U.S. corporate securities and U.S. government securities. Investments in common/collective trust funds are valued at their respective net asset value (“NAV”) per share/unit on the valuation date.

Separate Accounts financial assets at December 31, 2025 and 2024 were as follows:

	December 31, 2025				December 31, 2024			
In millions	**Level 1**	**Level 2**	**Level 3**	**Total**	**Level 1**	**Level 2**	**Level 3**	**Total**
Cash and cash equivalents	$ 1	$ 155	$ —	$ 156	$ 1	$ 164	$ —	$ 165
Debt securities	30	361	2	393	186	669	1	856
Common/collective trusts	—	1,445	—	1,445	—	2,478	—	2,478
Total [1]	$ 31	$ 1,961	$ 2	$ 1,994	$ 187	$ 3,311	$ 1	$ 3,499

(1) Excludes $188 million of other payables at December 31, 2024.

During the years ended December 31, 2025 and 2024, the Company had no gross transfers of Separate Accounts financial assets into or out of Level 3.

6. 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, 2025 and 2024:

In millions	**Health Care Benefits**	**Health Services**	**Pharmacy & Consumer Wellness**	**Total**
Balance at December 31, 2023	$ 46,644	$ 34,066	$ 10,562	$ 91,272
Balance at December 31, 2024	46,644	34,066	10,562	91,272
Impairment	—	(5,725)	—	(5,725)
Divestiture	—	(69)	—	(69)
Balance at December 31, 2025	$ 46,644	$ 28,272	$ 10,562	$ 85,478

During 2025, the Health Care Delivery reporting unit continued to experience challenges, including the impact of persistent elevated utilization levels. In order to best respond to these challenges, the Company made a number of changes to its Health Care Delivery management team during 2025. During the third quarter of 2025, this new management team finalized certain strategic changes, including the determination that it would reduce the number of new primary care clinics it would open in 2026 and annually thereafter. The Company also determined that it would close certain existing Oak Street Health clinics in 2026. The strategy changes were presented to CVS Health Corporation's Board of Directors in September 2025.

These changes are expected to impact management's ability to grow the business at the rate that was originally estimated when the Company acquired the associated care delivery assets in 2023 and when the prior year annual goodwill impairment test was performed. Accordingly, the Health Care Delivery management team updated its financial projections to reflect these changes for 2026 and beyond. Based on these updated projections, management determined that there were indicators that the Health Care Delivery reporting unit's goodwill may be impaired and, accordingly, an interim goodwill impairment test was performed during the third quarter of 2025.

The results of the impairment test showed that the fair value of the Health Care Delivery reporting unit was lower than its carrying value, resulting in a $5.7 billion goodwill impairment charge, which was recorded during the third quarter of 2025. The Company also performed an interim impairment test of the intangible assets of the Health Care Delivery reporting unit and no intangible assets were impaired as of September 30, 2025. The fair value of the Health Care Delivery reporting unit was determined using a combination of a discounted cash flow method and a market multiple method and utilized inputs that reflect the Company's assumptions, which are categorized as Level 3 inputs within the fair value hierarchy. In addition to the lower financial projections, lower market multiples of the peer group companies contributed to the amount of the goodwill impairment charge. As of December 31, 2025, the remaining goodwill balance in the Health Care Delivery reporting unit was approximately $4.2 billion.

During the fourth quarter of 2025, 2024 and 2023, the Company performed its required annual impairment tests of goodwill. The results of these impairment tests indicated that there was no impairment of goodwill as of the annual testing dates.

At December 31, 2025 and 2024, cumulative goodwill impairments were $5.7 billion and $6.6 billion, respectively. Cumulative goodwill impairments previously recorded on the long-term care reporting unit of $6.6 billion were eliminated in connection with the deconsolidation of the Omnicare Entities during the third quarter of 2025.

During the year ended December 31, 2025, the decrease in the carrying amount of goodwill also reflects the removal of goodwill in connection with the divestiture of the Company's MSSP operations as described in Note 2 ''Acquisition and Divestiture''.

Intangible Assets

The following table is a summary of the Company's intangible assets as of December 31, 2025 and 2024:

In millions, except weighted average life	**Gross Carrying Amount**	**Accumulated Amortization**	**Net Carrying Amount**	**Weighted Average Life (years)**
2025				
Trademarks (indefinite-lived)	$ 10,498	$ —	$ 10,498	N/A
Customer contracts/relationships and covenants not to compete	27,000	(15,427)	11,573	14.7
Technology	1,250	(1,230)	20	3.0
Provider networks	4,203	(1,492)	2,711	20.0
Value of Business Acquired	590	(255)	335	20.0
Other	824	(453)	371	9.4
Total	$ 44,365	$ (18,857)	$ 25,508	14.9
2024				
Trademarks (indefinite-lived)	$ 10,498	$ —	$ 10,498	N/A
Customer contracts/relationships and covenants not to compete	26,904	(13,889)	13,015	14.2
Technology	1,250	(1,167)	83	3.0
Provider networks	4,203	(1,282)	2,921	20.0
Value of Business Acquired	590	(228)	362	20.0
Other	826	(382)	444	9.3
Total	$ 44,271	$ (16,948)	$ 27,323	14.5

Amortization expense for intangible assets totaled $2.0 billion, $2.0 billion and $1.9 billion for the years ended December 31, 2025, 2024 and 2023, respectively. The projected annual amortization expense for the Company's intangible assets for the next five years is as follows:

In millions	
2026	$ 1,717
2027	1,604
2028	1,330
2029	1,252
2030	1,219

7. Leases

The Company leases most of its retail stores, mail order facilities and primary care centers, as well as certain distribution centers and corporate offices under operating or finance leases, typically with initial terms of 15 to 25 years. The Company also leases certain equipment and other assets under operating or finance leases, typically with initial terms of 3 to 10 years.

In addition, the Company leases pharmacy space at the stores of another retail chain for which the noncancelable contractual term of the pharmacy lease arrangement exceeds the remaining estimated economic life of the buildings. For these pharmacy lease arrangements, the Company concluded that for accounting purposes the lease term was the remaining estimated economic life of the buildings. Consequently, most of these individual pharmacy leases are finance leases.

The following table is a summary of the components of net lease cost for the years ended December 31, 2025, 2024 and 2023:

In millions	**2025**	**2024**	**2023**
Operating lease cost	$ 2,403	$ 2,423	$ 2,532
Finance lease cost:			
Amortization of right-of-use assets	90	92	84
Interest on lease liabilities	69	71	73
Total finance lease costs	159	163	157
Short-term lease costs	36	33	22
Variable lease costs	646	635	635
Less: sublease income	(69)	(67)	(63)
Net lease cost	$ 3,175	$ 3,187	$ 3,283

Supplemental cash flow information related to leases for the years ended December 31, 2025, 2024 and 2023 was as follows:

In millions	**2025**	**2024**	**2023**
Cash paid for amounts included in the measurement of lease liabilities:			
Operating cash flows paid for operating leases	$ 2,705	$ 2,733	$ 2,756
Operating cash flows paid for interest portion of finance leases	69	71	73
Financing cash flows paid for principal portion of finance leases	77	74	70
Right-of-use assets obtained in exchange for lease obligations:			
Operating leases	785	852	1,132
Finance leases	35	30	(4)

Supplemental balance sheet information related to leases as of December 31, 2025 and 2024 is as follows:

In millions, except remaining lease term and discount rate	2025	2024
Operating leases:		
Operating lease right-of-use assets	$ 14,973	$ 15,944
Current portion of operating lease liabilities	$ 1,737	$ 1,751
Long-term operating lease liabilities	13,643	14,899
Total operating lease liabilities	$ 15,380	$ 16,650
Finance leases:		
Property and equipment, gross	$ 1,622	$ 1,587
Accumulated depreciation	(528)	(447)
Property and equipment, net	$ 1,094	$ 1,140
Current portion of long-term debt	$ 61	$ 65
Long-term debt	1,265	1,295
Total finance lease liabilities	$ 1,326	$ 1,360
Weighted average remaining lease term *(in years)*		
Operating leases	10.0	10.7
Finance leases	15.7	16.5
Weighted average discount rate		
Operating leases	4.7 %	4.6 %
Finance leases	5.1 %	5.1 %

The following table summarizes the maturity of lease liabilities under finance and operating leases as of December 31, 2025:

In millions	Finance Leases	Operating Leases [1]	Total
2026	$ 139	$ 2,626	$ 2,765
2027	136	2,475	2,611
2028	133	2,300	2,433
2029	132	2,031	2,163
2030	129	1,789	1,918
Thereafter	1,291	8,166	9,457
Total lease payments [2]	1,960	19,387	21,347
Less: imputed interest	(634)	(4,007)	(4,641)
Total lease liabilities	$ 1,326	$ 15,380	$ 16,706

(1) Future operating lease payments have not been reduced by minimum sublease rentals of $298 million due in the future under noncancelable subleases.
(2) The Company leases pharmacy and clinic space from Target Corporation. Amounts related to such finance and operating leases are reflected above. Pharmacy lease amounts due in excess of the remaining estimated economic life of the buildings of approximately $2.3 billion are not reflected in this table since the estimated economic life of the buildings is shorter than the contractual term of the pharmacy lease arrangement.

8. Health Care Costs Payable

The following is information about incurred and cumulative paid health care claims development as of December 31, 2025, net of reinsurance, and the total IBNR liabilities plus expected development on reported claims included within the net incurred claims amounts. See Note 1 ‘‘Significant Accounting Policies’’ for information on how the Company estimates IBNR reserves and health care costs payable as well as changes to those methodologies, if any. The Company’s estimate of IBNR liabilities is primarily based on trend and completion factors. Claim frequency is not used in the calculation of the Company’s liability. In addition, it is impracticable to disclose claim frequency information for health care claims due to the Company’s inability to gather consistent claim frequency information across its multiple claims processing systems. Any claim frequency count disclosure would not be comparable across the Company’s different claim processing systems and would not be consistent from period to period based on the volume of claims processed through each system. As a result, health care claim count frequency is not included in the disclosures below.

The information about incurred and paid health care claims development for the year ended December 31, 2024 is presented as required unaudited supplemental information.

In millions	**Incurred Health Care Claims, Net of Reinsurance For the Years Ended December 31,**	
Date of Service	**2024**	**2025**
	(Unaudited)	
2024	$ 109,458	$ 107,650
2025		119,336
	Total	$ 226,986

In millions	**Cumulative Paid Health Care Claims, Net of Reinsurance For the Years Ended December 31,**	
Date of Service	**2024**	**2025**
	(Unaudited)	
2024	$ 97,155	$ 107,061
2025		107,721
	Total	$ 214,782
All outstanding liabilities for health care costs payable prior to 2024, net of reinsurance		322
Total outstanding liabilities for health care costs payable, net of reinsurance		$ 12,526

At December 31, 2025, the Company’s liabilities for IBNR plus expected development on reported claims totaled approximately $10.4 billion. Substantially all of the Company’s liabilities for IBNR plus expected development on reported claims at December 31, 2025 related to the current calendar year.

The reconciliation of the December 31, 2025 health care net incurred and paid claims development tables to the health care costs payable liability on the consolidated balance sheet were as follows:

In millions	**December 31, 2025**
Short-duration health care costs payable, net of reinsurance	$ 12,526
Reinsurance recoverables	90
Insurance lines other than short duration	234
Other non-insurance health care costs payable	2,549
Total health care costs payable	$ 15,399

The following table shows the components of the change in health care costs payable during the years ended December 31, 2025, 2024 and 2023:

In millions	**2025**	**2024**	**2023**
Health care costs payable, beginning of the period	$ 15,064	$ 12,049	$ 10,142
Less: Reinsurance recoverables	81	5	5
Less: Impact of discount rate on long-duration insurance reserves [1]	(1)	(23)	8
Health care costs payable, beginning of the period, net	14,984	12,067	10,129
Acquisition, net	—	—	1,098
Add: Components of incurred health care costs			
Current year	127,256	115,774	86,639
Prior years	(1,982)	(947)	(685)
Total incurred health care costs [2]	125,274	114,827	85,954
Less: Claims paid			
Current year	113,023	101,583	75,529
Prior years	11,906	10,327	9,585
Total claims paid	124,929	111,910	85,114
Health care costs payable, end of the period, net	15,329	14,984	12,067
Add: Reinsurance recoverables	90	81	5
Add: Impact of discount rate on long-duration insurance reserves [1]	(20)	(1)	(23)
Health care costs payable, end of the period	$ 15,399	$ 15,064	$ 12,049

(1) Reflects the difference between the current discount rate and the locked-in discount rate on long-duration insurance reserves which is recorded within accumulated other comprehensive income (loss) on the consolidated balance sheets.

(2) Total incurred health care costs for the years ended December 31, 2025, 2024 and 2023 in the table above exclude $87 million, $107 million and $83 million, respectively, of health care costs recorded in the Health Care Benefits segment that are included in other insurance liabilities on the consolidated balance sheets and $177 million, $187 million and $210 million, respectively, of health care costs recorded in the Corporate/Other segment that are included in other insurance liabilities on the consolidated balance sheets.

The Company's estimates of prior years' health care costs payable decreased by $2.0 billion, $947 million and $685 million in 2025, 2024 and 2023, respectively, because claims were settled for amounts less than originally estimated (i.e., the amount of claims incurred was lower than originally estimated), primarily due to lower than expected health care cost trends as well as the actual claim submission time being faster than originally assumed (i.e., the Company's completion factors were higher than originally assumed) in estimating health care costs payable at the end of the prior year. This development does not directly correspond to an increase in the Company's operating results as these reductions were offset by estimated current period health care costs when the Company established the estimate of the current year health care costs payable.

9. Other Insurance Liabilities and Separate Accounts

Future Policy Benefits

The following tables show the components of the change in the liability for future policy benefits, which is included in other insurance liabilities and other long-term insurance liabilities on the consolidated balance sheets, during the years ended December 31, 2025 and 2024:

	2025	
In millions	**Large Case Pensions**	**Long-Term Care**
Present value of expected net premiums [1]		
Liability for future policy benefits, beginning of period - current discount rate		$ 275
Beginning liability for future policy benefits at original (locked-in) discount rate		$ 280
Effect of changes in cash flow assumptions		—
Effect of actual variances from expected experience		7
Adjusted beginning liability for future policy benefits - original (locked-in) discount rate		287
Interest accrual (using locked-in discount rate)		14
Net premiums (actual)		(37)
Ending liability for future policy benefits at original (locked-in) discount rate		264
Effect of changes in discount rate assumptions		2
Liability for future policy benefits, end of period - current discount rate		$ 266
Present value of expected future policy benefits		
Liability for future policy benefits, beginning of period - current discount rate	$ 1,917	$ 1,552
Beginning liability for future policy benefits at original (locked-in) discount rate	$ 2,090	$ 1,647
Effect of changes in cash flow assumptions	—	—
Effect of actual variances from expected experience	(6)	3
Adjusted beginning liability for future policy benefits - original (locked-in) discount rate	2,084	1,650
Issuances	18	—
Interest accrual (using locked-in discount rate)	84	82
Benefit payments (actual)	(241)	(78)
Ending liability for future policy benefits at original (locked-in) discount rate	1,945	1,654
Effect of changes in discount rate assumptions	(120)	(58)
Liability for future policy benefits, end of period - current discount rate	$ 1,825	$ 1,596
Net liability for future policy benefits	$ 1,825	$ 1,330
Less: Reinsurance recoverable	—	—
Net liability for future policy benefits, net of reinsurance recoverable	$ 1,825	$ 1,330

(1) The present value of expected net premiums is equivalent to the present value of expected gross premiums for the long-term care insurance contracts as net premiums are set equal to gross premiums.

In millions	2024 Large Case Pensions	2024 Long-Term Care
Present value of expected net premiums [1]		
Liability for future policy benefits, beginning of period - current discount rate		$ 293
Beginning liability for future policy benefits at original (locked-in) discount rate		$ 288
Effect of changes in cash flow assumptions		—
Effect of actual variances from expected experience		16
Adjusted beginning liability for future policy benefits - original (locked-in) discount rate		304
Interest accrual (using locked-in discount rate)		14
Net premiums (actual)		(38)
Ending liability for future policy benefits at original (locked-in) discount rate		280
Effect of changes in discount rate assumptions		(5)
Liability for future policy benefits, end of period - current discount rate		$ 275
Present value of expected future policy benefits		
Liability for future policy benefits, beginning of period - current discount rate	$ 2,139	$ 1,640
Beginning liability for future policy benefits at original (locked-in) discount rate	$ 2,251	$ 1,632
Effect of changes in cash flow assumptions	—	—
Effect of actual variances from expected experience	(27)	6
Adjusted beginning liability for future policy benefits - original (locked-in) discount rate	2,224	1,638
Issuances	30	—
Interest accrual (using locked-in discount rate)	91	83
Benefit payments (actual)	(255)	(74)
Ending liability for future policy benefits at original (locked-in) discount rate	2,090	1,647
Effect of changes in discount rate assumptions	(173)	(95)
Liability for future policy benefits, end of period - current discount rate	$ 1,917	$ 1,552
Net liability for future policy benefits	$ 1,917	$ 1,277
Less: Reinsurance recoverable	—	—
Net liability for future policy benefits, net of reinsurance recoverable	$ 1,917	$ 1,277

(1) The present value of expected net premiums is equivalent to the present value of expected gross premiums for the long-term care insurance contracts as net premiums are set equal to gross premiums.

The Company did not have any material differences between the actual experience and expected experience for the significant assumptions used in the computation of the liability for future policy benefits.

The amount of undiscounted expected gross premiums and expected future benefit payments for long-duration insurance liabilities as of December 31, 2025 and 2024 were as follows:

In millions	**2025**	**2024**
Large case pensions		
Expected future benefit payments	$ 2,804	$ 3,024
Expected gross premiums	—	—
Long-term care		
Expected future benefit payments	$ 3,132	$ 3,189
Expected gross premiums	372	399

The weighted-average interest rate used in the measurement of the long-duration insurance liabilities as of December 31, 2025 and 2024 were as follows:

	2025	**2024**
Large case pensions		
Interest accretion rate	4.21%	4.20%
Current discount rate	5.13%	5.46%
Long-term care		
Interest accretion rate	5.11%	5.11%
Current discount rate	5.51%	5.70%

The weighted-average durations (in years) of the long-duration insurance liabilities as of December 31, 2025 and 2024 were as follows:

	2025	**2024**
Large case pensions	7.2	7.3
Long-term care	11.2	11.7

Separate Accounts

The following table shows the fair value of assets, by major investment category, supporting Separate Accounts as of December 31, 2025 and 2024:

In millions	2025	2024
Cash and cash equivalents	$ 156	$ 165
Debt securities:		
U.S. government securities	36	186
States, municipalities and political subdivisions	11	14
U.S. corporate securities	291	524
Foreign securities	39	51
Residential mortgage-backed securities	8	71
Commercial mortgage-backed securities	3	3
Other asset-backed securities	5	7
Total debt securities	393	856
Common/collective trusts	1,445	2,478
Total [(1)]	$ 1,994	$ 3,499

(1) Excludes $188 million of other payables at December 31, 2024.

The following table shows the components of the change in Separate Accounts liabilities during the years ended December 31, 2025 and 2024:

In millions	2025	2024
Separate Accounts liability, beginning of the period	$ 3,311	$ 3,250
Premiums and deposits	888	964
Surrenders and withdrawals	(1,336)	(277)
Benefit payments	(953)	(978)
Investment earnings	84	348
Net transfers from general account	8	13
Other	(8)	(9)
Separate Accounts liability, end of the period	$ 1,994	$ 3,311
Cash surrender value, end of the period	$ 933	$ 1,987

The Company did not recognize any gains or losses on assets transferred to Separate Accounts during the years ended December 31, 2025 or 2024.

10. Borrowings and Credit Agreements

The following table is a summary of the Company's borrowings as of December 31, 2025 and 2024:

In millions	2025	2024
Short-term debt		
Commercial paper	$ —	$ 2,119
Long-term debt		
4.1% senior notes due March 2025	—	724
3.875% senior notes due July 2025	—	2,828
5% senior notes due February 2026	1,500	1,500
2.875% senior notes due June 2026	1,750	1,750
3% senior notes due August 2026	750	750
3.625% senior notes due April 2027	750	750
6.25% senior notes due June 2027	372	372
1.3% senior notes due August 2027	2,250	2,250
4.3% senior notes due March 2028	5,000	5,000
5% senior notes due January 2029	1,000	1,000
5.4% senior notes due June 2029	1,000	1,000
3.25% senior notes due August 2029	1,750	1,750
5.125% senior notes due February 2030	1,500	1,500
3.75% senior notes due April 2030	1,500	1,500
1.75% senior notes due August 2030	1,250	1,250
5.25% senior notes due January 2031	750	750
1.875% senior notes due February 2031	1,250	1,250
5.55% senior notes due June 2031	1,000	1,000
2.125% senior notes due September 2031	1,000	1,000
5% senior notes due September 2032	750	—
5.25% senior notes due February 2033	1,750	1,750
5.3% senior notes due June 2033	1,250	1,250
5.7% senior notes due June 2034	1,250	1,250
4.875% senior notes due July 2035	652	652
5.45% senior notes due September 2035	1,500	—
6.625% senior notes due June 2036	771	771
6.75% senior notes due December 2037	533	533
4.78% senior notes due March 2038	5,000	5,000
6.125% senior notes due September 2039	447	447
4.125% senior notes due April 2040	602	602
2.7% senior notes due August 2040	367	367
5.75% senior notes due May 2041	133	133
4.5% senior notes due May 2042	500	500
4.125% senior notes due November 2042	226	226
5.3% senior notes due December 2043	750	750
4.75% senior notes due March 2044	375	375
6% senior notes due June 2044	750	750
5.125% senior notes due July 2045	3,500	3,500
3.875% senior notes due August 2047	537	537
5.05% senior notes due March 2048	8,000	8,000
4.25% senior notes due April 2050	399	399
5.625% senior notes due February 2053	1,250	1,250
5.875% senior notes due June 2053	1,250	1,250

6.05% senior notes due June 2054	1,000	1,000
6.2% senior notes due September 2055	1,250	—
6% senior notes due June 2063	750	750
6.25% senior notes due September 2065	500	—
6.75% series B junior subordinated notes due December 2054	750	750
7% series A junior subordinated notes due March 2055	2,250	2,250
Finance lease liabilities	1,326	1,360
Other	295	302
Total debt principal	65,035	66,747
Debt premiums	156	170
Debt discounts and deferred financing costs	(621)	(647)
	64,570	66,270
Less:		
Short-term debt (commercial paper)	—	(2,119)
Current portion of long-term debt	(4,068)	(3,624)
Long-term debt	$ 60,502	$ 60,527

The following is a summary of the Company's required repayments of long-term debt principal due during each of the next five years and thereafter, as of December 31, 2025:

In millions	
2026	$ 4,007
2027	3,379
2028	5,008
2029	3,758
2030	4,258
Thereafter	43,299
Subtotal	63,709
Finance lease liabilities [(1)]	1,326
Total debt principal	$ 65,035

(1) See Note 7 ''Leases'' for a summary of maturities of the Company's finance lease liabilities.

Short-term Borrowings

Commercial Paper and Back-up Credit Facilities

The Company did not have any commercial paper outstanding as of December 31, 2025. The Company had $2.1 billion of commercial paper outstanding at a weighted interest rate of 4.98% as of December 31, 2024. In connection with its commercial paper program, the Company maintains three $2.5 billion, five-year unsecured back-up revolving credit facilities, which expire in May 2028, 2029 and 2030. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately 0.03%, regardless of usage. As of December 31, 2025 and 2024, there were no borrowings outstanding under any of the Company's back-up credit facilities.

Term Loan Agreement

On March 25, 2024, the Company entered into a 364-day $3.0 billion term loan credit agreement. The term loan credit agreement allowed for borrowings at various rates that were dependent, in part, on the Company's public debt ratings. On May 9, 2024, following the issuance of the $5.0 billion in senior notes described under "Long-term Borrowings" below, the term loan credit agreement terminated. There were no borrowings under the term loan credit agreement through the date of termination.

FHLBB
A subsidiary of the Company is a member of the FHLBB. As a member, the subsidiary has the ability to obtain cash advances, subject to certain minimum collateral requirements. The maximum borrowing capacity available from the FHLBB as of December 31, 2025 was approximately $1.3 billion. As of December 31, 2025 and 2024, there were no outstanding advances from the FHLBB.

Long-term Borrowings

2025 Notes
On August 15, 2025, the Company issued $750 million aggregate principal amount of 5.0% senior notes due September 2032, $1.5 billion aggregate principal amount of 5.45% senior notes due September 2035, $1.25 billion aggregate principal amount of 6.2% senior notes due September 2055 and $500 million aggregate principal amount of 6.25% senior notes due September 2065 for total proceeds of approximately $4.0 billion, net of discounts and underwriting fees. The net proceeds of these offerings were used to repay existing indebtedness, including borrowings under the Company's commercial paper program, as well as for general corporate purposes.

2024 Notes
On December 10, 2024, the Company issued $2.25 billion aggregate principal amount of 7.0% fixed-to-fixed rate series A junior subordinated notes due March 2055 and $750 million aggregate principal amount of 6.75% fixed-to-fixed rate series B junior subordinated notes due December 2054 for total proceeds of approximately $3.0 billion, net of discounts and underwriting fees. The series A junior subordinated notes bear interest at 7.0% per year until March 10, 2030, at which time the rate will reset March 10th of every fifth year, provided that the interest rate will not reset below the initial interest rate. The series B junior subordinated notes bear interest at 6.75% per year until December 10, 2034, at which time the rate will reset December 10th of every fifth year, provided that the interest rate will not reset below the initial interest rate. The series A and series B junior subordinated notes pay interest semi-annually and may be redeemed at any time beginning 90 days prior to their respective first interest rate reset date and on any interest payment date thereafter, in whole or in part at a defined redemption price plus accrued interest. The net proceeds of these offerings were used for the early extinguishment of certain of the Company's senior notes as described below and the remaining proceeds after the early extinguishment of debt were used for general corporate purposes.

On May 9, 2024, the Company issued $1.0 billion aggregate principal amount of 5.4% senior notes due June 2029, $1.0 billion aggregate principal amount of 5.55% senior notes due June 2031, $1.25 billion aggregate principal amount of 5.7% senior notes due June 2034, $750 million aggregate principal amount of 6.0% senior notes due June 2044 and $1.0 billion aggregate principal amount of 6.05% senior notes due June 2054 for total proceeds of approximately $5.0 billion, net of discounts and underwriting fees. The net proceeds of these offerings were used for general corporate purposes.

Gain on Early Extinguishment of Debt
In December 2024, pursuant to a cash tender offer, the Company repaid approximately $2.6 billion of its outstanding senior notes for a cash payment of approximately $2.0 billion. The senior notes purchased include: $226 million of its 4.1% senior notes due March 2025, $398 million of its 4.125% senior notes due April 2040, $883 million of its 2.7% senior notes due August 2040, $274 million of its 4.125% senior notes due November 2042, $463 million of its 3.875% senior notes due August 2047 and $351 million of its 4.25% senior notes due April 2050. In connection with the purchase of such senior notes, the Company recognized a total gain on early extinguishment of debt of $491 million, net of unamortized deferred financing costs and incurred fees.

Debt Covenants

The Company's back-up revolving credit facilities and unsecured senior notes contain customary restrictive financial and operating covenants. These covenants do not include an acceleration of the Company's debt maturities in the event of a downgrade in the Company's credit ratings. The Company does not believe the restrictions contained in these covenants materially affect its financial or operating flexibility. As of December 31, 2025, the Company was in compliance with all of its debt covenants.

11. Pension Plans and Other Postretirement Benefits

Defined Contribution Plans

As of December 31, 2025, the Company sponsors 401(k) savings plans that cover all employees who meet plan eligibility requirements. The Company makes matching contributions consistent with the provisions of the respective plans. At the participant's option, account balances, including the Company's matching contribution, can be invested among various investment options under each plan. The CVS Health Future Fund 401(k) Plan offers CVS Health Corporation's common stock fund as an investment option. The Company also maintains nonqualified, unfunded deferred compensation plans for certain key employees. The plans provide participants the opportunity to defer portions of their eligible compensation and for certain nonqualified plans, participants receive matching contributions equivalent to what they could have received under the CVS Health Future Fund 401(k) Plan absent certain restrictions and limitations under the Internal Revenue Code. The Company's contributions under its defined contribution plans were $657 million, $610 million and $581 million in the years ended December 31, 2025, 2024 and 2023, respectively.

Defined Benefit Pension Plans

The Company sponsors a tax-qualified defined benefit pension plan that was frozen in 2010 and a nonqualified supplemental pension plan that was frozen in 2007. The Company also sponsors several other defined benefit pension plans that are unfunded nonqualified supplemental retirement plans.

Pension Benefit Obligation and Plan Assets
The following tables outline the change in pension benefit obligation and plan assets over the specified periods:

In millions	**2025**	**2024**
Change in benefit obligation:		
Benefit obligation, beginning of year	$ 4,349	$ 4,736
Interest cost	221	222
Actuarial loss (gain)	123	(262)
Benefit payments	(356)	(347)
Benefit obligation, end of year	4,337	4,349
Change in plan assets:		
Fair value of plan assets, beginning of year	5,188	5,379
Actual return on plan assets	433	133
Employer contributions	22	23
Benefit payments	(356)	(347)
Fair value of plan assets, end of year	5,287	5,188
Funded status	$ 950	$ 839

The change in the pension benefit obligation during the years ended December 31, 2025 and 2024 was primarily driven by the change in the discount rate during each respective period.

The assets (liabilities) recognized on the consolidated balance sheets at December 31, 2025 and 2024 for the defined benefit pension plans consisted of the following:

In millions	**2025**	**2024**
Noncurrent assets reflected in other assets	$ 1,137	$ 1,030
Current liabilities reflected in accrued expenses and other current liabilities	(22)	(22)
Noncurrent liabilities reflected in other long-term liabilities	(165)	(169)
Net assets	$ 950	$ 839

Net Periodic Benefit Cost (Income)
The components of net periodic benefit cost (income) for the years ended December 31, 2025, 2024 and 2023 are shown below:

In millions	**2025**	**2024**	**2023**
Components of net periodic benefit cost (income):			
Interest cost	$ 221	$ 222	$ 231
Expected return on plan assets	(339)	(327)	(326)
Amortization of net actuarial loss	1	1	1
Net periodic benefit cost (income)	$ (117)	$ (104)	$ (94)

Pension Plan Assumptions
The Company uses a series of actuarial assumptions to determine its benefit obligation and net periodic benefit income, the most significant of which include discount rates and expected return on plan assets assumptions.

Discount Rates - The discount rate is determined using a yield curve as of the annual measurement date. The yield curve consists of a series of individual discount rates, with each discount rate corresponding to a single point in time, based on high-quality bonds. Projected benefit payments are discounted to the measurement date using the corresponding rate from the yield curve that is consistent with the maturity profile of the expected liability cash flows.

Expected Return on Plan Assets - The expected long-term rate of return on plan assets is determined by using the plan's target allocation and return expectations based on many factors including forecasted long-term capital market real returns and the inflationary outlook on a plan-by-plan basis. See "Pension Plan Assets" below for additional details regarding the pension plan assets as of December 31, 2025 and 2024.

The Company also considers other assumptions including mortality, interest crediting rate, termination and retirement rates, and cost of living adjustments.

The Company determined its benefit obligation based on the following weighted average assumptions as of December 31, 2025 and 2024:

	2025	**2024**
Discount rate	5.3 %	5.6 %

The Company determined its net periodic benefit cost (income) based on the following weighted average assumptions for the years ended December 31, 2025, 2024 and 2023:

	2025	**2024**	**2023**
Discount rate	5.3 %	4.9 %	5.1 %
Expected long-term rate of return on plan assets	6.8 %	6.3 %	6.3 %

Pension Plan Assets
The Company's pension plan assets primarily include debt and equity securities held in separate accounts, common/collective trusts, as well as Private Real Estate, Farmland, Public Real Estate and Public Infrastructure (collectively referred to as "Real Assets") and private credit. The valuation methodologies used to value these debt and equity securities and common/collective trusts are similar to the methodologies described in Note 5 ''Fair Value''. Pension plan assets also include investments in other assets that are carried at fair value. The following is a description of the valuation methodologies used to value private real estate investments and these additional investments, including the general classification pursuant to the fair value hierarchy.

Private real estate - Private real estate investments are valued by independent third-party appraisers. The appraisals comply with the Uniform Standards of Professional Appraisal Practice, which include, among other things, the income, cost, and sales comparison approaches to estimating property value. Therefore, these investments are classified in Level 3.

Private equity, private credit and hedge fund limited partnerships - Private equity and hedge fund limited partnerships are carried at fair value which is estimated using the NAV per unit as reported by the administrator of the underlying

investment fund as a practical expedient to fair value. Therefore, these investments have been excluded from the fair value table below.

Pension plan assets with changes in fair value measured on a recurring basis at December 31, 2025 were as follows:

In millions	**Level 1**	**Level 2**	**Level 3**	**Total**
Cash and cash equivalents	$ 25	$ 91	$ —	$ 116
Debt securities:				
U.S. government securities	528	19	—	547
States, municipalities and political subdivisions	—	73	—	73
U.S. corporate securities	—	2,391	2	2,393
Foreign securities	—	82	—	82
Commercial mortgage-backed securities	—	9	—	9
Other asset-backed securities	—	9	—	9
Total debt securities	528	2,583	2	3,113
Equity securities:				
U.S. domestic	101	—	—	101
International	25	13	—	38
Total equity securities	126	13	—	139
Other investments:				
Private real estate	—	—	182	182
Common/collective trusts [1]	—	958	—	958
Derivatives	—	10	—	10
Total other investments	—	968	182	1,150
Total pension investments [2]	$ 679	$ 3,655	$ 184	$ 4,518

(1) The assets in the underlying funds of common/collective trusts consist of $284 million of equity securities and $674 million of debt securities.
(2) Excludes $212 million of other receivables as well as $278 million of private equity limited partnership investments and $279 million of hedge fund limited partnership investments as these amounts are measured at NAV per share or an equivalent and are not subject to leveling within the fair value hierarchy.

Pension plan assets with changes in fair value measured on a recurring basis at December 31, 2024 were as follows:

In millions	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 32	$ 67	$ —	$ 99
Debt securities:				
U.S. government securities	481	6	—	487
States, municipalities and political subdivisions	—	70	—	70
U.S. corporate securities	—	2,752	1	2,753
Foreign securities	—	98	—	98
Residential mortgage-backed securities	—	7	—	7
Commercial mortgage-backed securities	—	9	—	9
Other asset-backed securities	—	4	—	4
Redeemable preferred securities	—	1	—	1
Total debt securities	481	2,947	1	3,429
Equity securities:				
U.S. domestic	30	—	—	30
International	12	—	—	12
Total equity securities	42	—	—	42
Other investments:				
Private real estate	—	—	276	276
Common/collective trusts [1]	—	502	—	502
Derivatives	—	3	—	3
Total other investments	—	505	276	781
Total pension investments [2]	$ 555	$ 3,519	$ 277	$ 4,351

(1) The assets in the underlying funds of common/collective trusts consist of $288 million of equity securities and $214 million of debt securities.
(2) Excludes $267 million of other receivables as well as $290 million of private equity limited partnership investments and $280 million of hedge fund limited partnership investments as these amounts are measured at NAV per share or an equivalent and are not subject to leveling within the fair value hierarchy.

The changes in the balances of Level 3 pension plan assets during the year ended December 31, 2025 were as follows:

In millions	Private real estate	U.S. corporate securities	Total
Beginning balance	$ 276	$ 1	$ 277
Actual return on plan assets	(16)	—	(16)
Purchases, sales and settlements	(78)	1	(77)
Transfers out of Level 3	—	—	—
Ending balance	$ 182	$ 2	$ 184

The changes in the balances of Level 3 pension plan assets during the year ended December 31, 2024 were as follows:

In millions	Private real estate	U.S. corporate securities	Total
Beginning balance	$ 290	$ —	$ 290
Actual return on plan assets	1	—	1
Purchases, sales and settlements	(15)	1	(14)
Transfers out of Level 3	—	—	—
Ending balance	$ 276	$ 1	$ 277

The Company's pension plan invests in a diversified mix of assets designed to generate returns that will enable the plan to meet its future benefit obligations. The risk of unexpected investment and actuarial outcomes is regularly evaluated. This evaluation is performed through forecasting and assessing ranges of investment outcomes over short- and long-term horizons and by assessing the pension plan's liability characteristics. Complementary investment styles and strategies are utilized by professional investment management firms to further improve portfolio and operational risk characteristics. Public and private equity investments are used primarily to increase overall plan returns. Real Assets 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, 2025, target investment allocations for the Company's pension plan were: 7% in equity securities, 75% in fixed income and debt securities, 7% in Real Assets, 5% in private equity limited partnerships, 2% in private credit limited partnerships and 4% in hedge funds. Actual asset allocations may differ from target allocations due to tactical decisions to overweight or underweight certain assets or as a result of normal fluctuations in asset values. Asset allocations are consistent with stated investment policies and, as a general rule, periodically rebalanced back to target asset allocations. Asset allocations and investment performance are formally reviewed periodically throughout the year by the pension plan's Investment Subcommittee. Forecasting of asset and liability growth is performed at least annually.

Cash Flows
The Company generally contributes to its tax-qualified pension plan based on minimum funding requirements determined under applicable federal laws and regulations. Employer contributions related to the nonqualified supplemental pension plans generally represent payments to retirees for current benefits. The Company's contributions to its pension plans during the years ended December 31, 2025, 2024 and 2023 were not material. No contributions were required for the tax-qualified pension plan in 2025. The Company expects to make an immaterial amount of contributions for all other pension plans in 2026.

The Company estimates the following future benefit payments, which are calculated using the same actuarial assumptions used to measure the pension benefit obligation as of December 31, 2025:

In millions		
2026	$	387
2027		383
2028		382
2029		375
2030		365
2031-2035		1,674

Multiemployer Pension Plans
The Company also contributes to a number of multiemployer pension plans under the terms of collective-bargaining agreements that cover its union-represented employees. The risks of participating in these multiemployer plans are different from single-employer pension plans in the following respects: (i) assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers, (ii) if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers, and (iii) if the Company chooses to stop participating in some of its multiemployer plans, the Company may be required to pay those plans an amount based on the underfunded status of the applicable plan, which is referred to as a withdrawal liability.

None of the multiemployer pension plans in which the Company participates are individually significant to the Company. The Company's contributions to multiemployer pension plans were not material in the years ended December 31, 2025, 2024 and 2023.

Other Postretirement Benefits

The Company provides postretirement health care and life insurance benefits to certain retirees who meet eligibility requirements. The Company's funding policy is generally to pay covered expenses as they are incurred. For retiree medical plan accounting, the Company reviews external data and its own historical trends for health care costs to determine the health care cost trend rates. As of December 31, 2025 and 2024, the Company's other postretirement benefits had an accumulated postretirement benefit obligation of $151 million and $147 million, respectively. The net periodic benefit cost related to these other postretirement benefits was not material in the years ended December 31, 2025, 2024 and 2023.

The Company estimates the following future benefit payments, which are calculated using the same actuarial assumptions used to measure the accumulated other postretirement benefit obligation as of December 31, 2025:

In millions	
2026	$ 13
2027	13
2028	13
2029	13
2030	13
2031-2035	61

Pursuant to various collective bargaining agreements, the Company also contributes to multiemployer health and welfare plans that cover certain union-represented employees. The plans provide postretirement health care and life insurance benefits to certain employees who meet eligibility requirements. The Company's contributions to multiemployer health and welfare plans were not material in the years ended December 31, 2025, 2024 and 2023.

12. Income Taxes

The components of income before income tax provision, based on tax jurisdiction, consisted of the following for the years ended December 31, 2025, 2024 and 2023:

In millions	**2025**	**2024**	**2023**
Income before income tax provision:			
United States	$ 1,335	$ 5,964	$ 11,107
Foreign	801	184	66
Total	$ 2,136	$ 6,148	$ 11,173

The income tax provision (benefit) consisted of the following for the years ended December 31, 2025, 2024 and 2023:

In millions	**2025**	**2024**	**2023**
Current:			
Federal	$ (217)	$ 1,622	$ 2,814
State	409	476	662
Foreign	114	36	5
Total current	306	2,134	3,481
Deferred:			
Federal	92	(456)	(543)
State	10	(119)	(139)
Foreign	—	3	6
Total deferred	102	(572)	(676)
Total income tax provision (benefit):			
Federal	(125)	1,166	2,271
State	419	357	523
Foreign	114	39	11
Total	$ 408	$ 1,562	$ 2,805

The following table is a reconciliation of the statutory income tax rate to the Company's effective income tax rate for the years ended December 31, 2025, 2024 and 2023:

	2025		2024			2023		
In millions, except percentages	**$**	**%**	**$**	**%**		**$**	**%**	
Federal statutory tax rate	$ 449	21.0 %	$ 1,291	21.0 %		$ 2,346	21.0 %	
State and local income taxes, net of federal income tax effect	340	15.9	302	4.9		435	3.9	
Foreign tax effects:								
Ireland								
Statutory tax rate difference between Ireland and United States	(66)	(3.1)	—	—	*	—	—	
Other	19	0.9	—	—	*	—	—	
Total foreign tax effects	(47)	(2.2)	(15)	(0.2)		7	0.1	
Effect of changes in tax laws or rates enacted in the current period	—	—	—	—		—	—	
Effect of cross-border tax laws:								
Global intangible low-taxed income	38	1.7	—	—	*	—	—	
Foreign base company income	27	1.3	—	—	*	—	—	
Total effect of cross-border tax laws	65	3.0	20	0.3		—	—	
Tax credits:								
Research and development tax credits	(50)	(2.3)	—	—	*	—	—	*
Energy related tax credits	(76)	(3.6)	—	—	*	—	—	
Low-income housing tax credits	(25)	(1.2)	—	—	*	—	—	*
Other	(16)	(0.7)	—	—	*	—	—	*
Total tax credits	(167)	(7.8)	(92)	(1.5)		(62)	(0.6)	
Changes in valuation allowances	(7)	(0.3)	57	0.9		28	0.2	
Nontaxable or nondeductible items:								
Recognition of basis difference in subsidiaries	(1,793)	(83.9)	(71)	(1.2)		—	—	
Gain on deconsolidation	(101)	(4.7)	—	—		—	—	
Goodwill impairment	1,202	56.3	—	—		—	—	
Nondeductible litigation	324	15.2	—	—	*	—	—	*
Compensation	72	3.3	—	—	*	—	—	*
Other	7	0.3	99	1.7		65	0.6	
Total nontaxable or nondeductible items	(289)	(13.5)	28	0.5		65	0.6	
Changes in unrecognized tax benefits	64	3.0	(29)	(0.5)		(14)	(0.1)	
Effective income tax rate	$ 408	19.1 %	$ 1,562	25.4 %		$ 2,805	25.1 %	

* The impact to the income tax rate is immaterial for separate disclosure in the respective period.

Following the voluntarily initiation of Chapter 11 proceedings under the U.S. Bankruptcy Code described in "Subsidiary Bankruptcy" within Note 1 ''Significant Accounting Policies'', it was determined that the Company's investment in a subsidiary became worthless in 2025. Consequently, the Company recognized a related net tax benefit of approximately $1.9 billion in the aggregate during the year ended December 31, 2025.

For the year ended December 31, 2025, state and local income taxes in New York, California, Florida, New Jersey and Pennsylvania comprise the majority of the state and local income taxes, net of federal income tax effect category. For the years ended December 31, 2024 and 2023, state and local income taxes in New York, California, Florida and Illinois comprise the majority of the state and local income taxes, net of federal income tax effect category.

Income taxes paid, net of refunds received consisted of the following for the years ended December 31, 2025, 2024 and 2023:

In millions	**2025**	**2024**	**2023**
Income taxes paid, net of refunds received:			
Federal	$ 1,583	$ 1,194	$ 2,797
State	457	484	725
Foreign	126	25	2
Total	$ 2,166	$ 1,703	$ 3,524

The following table is a summary of the components of the Company's deferred income tax assets and liabilities as of December 31, 2025 and 2024:

In millions	**2025**	**2024**
Deferred income tax assets:		
Lease and rents	$ 4,435	$ 4,763
Legal charges	1,011	1,109
Inventory	70	68
Employee benefits	171	168
Bad debts and other allowances	682	593
Net operating loss and other carryovers	793	272
Deferred income	35	47
Insurance reserves	360	381
Investments	—	21
Other	456	486
Valuation allowance	(487)	(301)
Total deferred income tax assets	7,526	7,607
Deferred income tax liabilities:		
Investments	134	—
Retirement benefits	190	172
Lease and rents	3,872	4,125
Depreciation and amortization	7,162	7,116
Total deferred income tax liabilities	11,358	11,413
Net deferred income tax liabilities	$ 3,832	$ 3,806

When evaluating the realizability of deferred tax assets, the Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax planning strategies and the Company's recent operating results. The Company established a valuation allowance of $487 million and $301 million as of December 31, 2025 and 2024, respectively, because it does not consider it more likely than not that certain deferred tax assets will be recovered.

As of December 31, 2025, the Company had net operating loss and other carryovers of $793 million, a portion of which has an indefinite carryforward period, while the remainder expires between 2026 and 2046.

A reconciliation of the beginning and ending balance of unrecognized tax benefits in 2025, 2024 and 2023 is as follows:

In millions	**2025**	**2024**	**2023**
Beginning balance	$ 424	$ 436	$ 446
Additions based on tax positions related to the current year	—	—	2
Additions based on tax positions related to prior years	106	67	46
Reductions for tax positions of prior years	—	(49)	(24)
Expiration of statutes of limitation	(40)	(29)	(34)
Settlements	(66)	(1)	—
Ending balance	$ 424	$ 424	$ 436

CVS Health Corporation and most of its subsidiaries are subject to U.S. federal income tax as well as income tax of numerous state and local jurisdictions. The IRS has completed its examinations of the Company's consolidated U.S. federal income tax returns for tax years through 2016, 2018 and 2019. The IRS has substantially completed its examination of the Company's consolidated U.S. federal income tax return for tax year 2017.

CVS Health Corporation and its subsidiaries are also currently under income tax examinations by a number of state and local tax authorities. As of December 31, 2025, no examination has resulted in any proposed adjustments that would result in a material change to the Company's operating results, financial condition or liquidity.

Substantially all material state and local income tax matters have been concluded for fiscal years through 2018. Certain state exams are likely to be concluded and certain state statutes of limitations will lapse in 2026, 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 certain previous 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 $42 million, $45 million and $31 million in 2025, 2024 and 2023, respectively. The Company had approximately $175 million and $165 million accrued for interest and penalties as of December 31, 2025 and 2024, respectively.

As of December 31, 2025, the total amount of unrecognized tax benefits that, if recognized, would affect the Company's effective income tax rate is approximately $325 million, after considering the federal benefit of state income taxes.

13. Stock Incentive Plans

The terms of the CVS Health 2017 Incentive Compensation Plan ("ICP") provide for grants of annual incentive and long-term performance awards to executive officers and other officers and employees of the Company or any subsidiary of the Company, as well as equity compensation to outside directors of CVS Health Corporation. Payment of such annual incentive and long-term performance awards will be in cash, stock, other awards or other property, at the discretion of the Management Planning and Development Committee (the "MP&D Committee") of CVS Health Corporation's Board of Directors (the "Board"). The ICP allows for a maximum of 92 million shares of CVS Health Corporation common stock to be reserved and available for grants. As of December 31, 2025, there were approximately 27 million shares of CVS Health Corporation common stock available for future grants under the ICP.

Stock-Based Compensation Expense

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as expense over the requisite service period of the stock award (generally three to five years) using the straight-line method. The following table is a summary of stock-based compensation for the years ended December 31, 2025, 2024 and 2023:

In millions	**2025**	**2024**	**2023**
Restricted stock units and performance stock units	$ 467	$ 461	$ 497
Stock options and stock appreciation rights ("SARs") [1]	68	79	91
Total stock-based compensation	$ 535	$ 540	$ 588

(1) Includes the Employee Stock Purchase Plan ("ESPP").

Restricted Stock Units and Performance Stock Units

The Company's restricted stock units and performance stock units are considered nonvested share awards and require no payment from the employee. The fair value of the restricted stock units is based on the market price of CVS Health Corporation common stock on the grant date and is recognized on a straight-line basis over the vesting period. For each restricted stock unit granted, employees receive one share of common stock, net of taxes, at the end of the vesting period.

The Company's performance stock units contain performance vesting conditions in addition to a service vesting condition. Vesting of the Company's performance stock units is dependent upon the degree to which the Company achieves its performance goals, which are generally set for a three-year performance period and are approved at the time of grant by the MP&D Committee.

The fair value of performance stock units granted with service and performance vesting conditions is based on the market price of CVS Health Corporation common stock on the grant date and is recognized over the vesting period. Certain of the performance stock units also contain a market vesting condition based on the performance of CVS Health Corporation common stock relative to a comparator group. The fair value of these performance stock units is determined using a Monte Carlo simulation as of the grant date and is recognized over the vesting period.

As of December 31, 2025, there was $819 million of total unrecognized compensation cost related to the Company's restricted stock units and performance stock units that are expected to vest. These costs are expected to be recognized over a weighted-average period of 2.4 years. The total fair value of restricted stock units vested during the years ended December 31, 2025, 2024 and 2023 was $455 million, $497 million and $525 million, respectively.

The following table is a summary of the restricted stock unit and performance stock unit activity for the year ended December 31, 2025:

In thousands, except weighted average grant date fair value	**Units**	**Weighted Average Grant Date Fair Value**
Outstanding at beginning of year, nonvested	18,512	$ 77.19
Granted	9,256	$ 68.71
Vested [1]	(5,834)	$ 78.04
Forfeited	(3,086)	$ 78.25
Outstanding at end of year, nonvested	18,848	$ 72.59

(1) Vested performance stock units have been included at target level performance. Based on actual performance, the number of restricted stock units and performance stock units vested during the year ended December 31, 2025 was 5.9 million.

Stock Options and SARs

All stock option and SARs grants are awarded at fair value on the date of grant. The fair value of stock options and SARs are 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 and SARs granted generally become exercisable over a four-year period from

the grant date. Stock options granted through 2018 generally expire seven years after the grant date. Stock options and SARs granted subsequent to 2018 generally expire ten years after the grant date.

The following table is a summary of stock option and SAR activity for the years ended December 31, 2025, 2024 and 2023:

In millions	**2025**	**2024**	**2023**
Cash received from stock options exercised (including ESPP)	$ 394	$ 361	$ 277
Payments for taxes for net share settlement of equity awards	158	185	181
Intrinsic value of stock options and SARs exercised	41	33	31
Fair value of stock options and SARs vested	229	225	227

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:

	2025	**2024**	**2023**
Dividend yield [1]	3.95 %	4.29 %	3.27 %
Expected volatility [2]	30.43 %	28.36 %	28.15 %
Risk-free interest rate [3]	4.15 %	4.13 %	3.55 %
Expected life (in years) [4]	6.3	5.3	5.9
Weighted-average grant date fair value	$ 15.82	$ 11.31	$ 21.78

(1) The dividend yield is based on annual dividends paid and the fair market value of CVS Health Corporation stock at the grant date.
(2) The expected volatility is estimated based on the historical volatility of CVS Health Corporation's daily stock price over a period equal to the expected life of each option grant after adjustments for infrequent events such as stock splits.
(3) The risk-free interest rate is selected based on yields from U.S. Treasury zero-coupon issues with a remaining term equal to the expected term of the options being valued.
(4) The expected life represents the number of years the options are expected to be outstanding from grant date based on historical option or SAR holder exercise experience.

As of December 31, 2025, unrecognized compensation expense related to unvested stock options and SARs totaled $28 million, which the Company expects to be recognized over a weighted-average period of 1.8 years. After considering anticipated forfeitures, the Company expects approximately 4 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, 2025:

In thousands, except weighted average exercise price and remaining contractual term	**Shares**	**Weighted Average Exercise Price**	**Weighted Average Remaining Contractual Term**	**Aggregate Intrinsic Value**
Outstanding at beginning of year	15,019	$ 68.69		
Granted	733	$ 67.32		
Exercised	(3,919)	$ 58.13		
Forfeited	(364)	$ 70.83		
Expired	(726)	$ 79.33		
Outstanding at end of year	10,743	$ 71.68	5.29	$ 109,757
Exercisable at end of year	6,076	$ 71.55	4.37	68,079
Vested at end of year and expected to vest in the future	10,450	$ 71.74	5.23	106,818

ESPP

The Company's ESPP provides for the purchase of up to 60 million shares of CVS Health Corporation common stock. Under the ESPP, eligible employees may purchase common stock at the end of each six-month offering period at a purchase price equal to 90% of the lower of the fair market value on the first day or the last day of the offering period. During 2025, approximately 5 million shares of common stock were purchased under the provisions of the ESPP at an average price of

$40.85 per share. As of December 31, 2025, approximately 18 million shares of common stock were available for issuance under the ESPP.

The fair value of stock-based compensation associated with the ESPP is estimated on the date of grant (the first day of the six-month offering period) using the Black-Scholes option pricing model.

The following table is a summary of the assumptions used to value the ESPP awards for the years ended December 31, 2025, 2024 and 2023:

	2025	2024	2023
Dividend yield [1]	2.60 %	2.01 %	1.54 %
Expected volatility [2]	37.40 %	31.40 %	25.61 %
Risk-free interest rate [3]	4.27 %	5.31 %	5.17 %
Expected life (in years) [4]	0.5	0.5	0.5
Weighted-average grant date fair value	$ 10.30	$ 12.39	$ 14.26

(1) The dividend yield is calculated based on semi-annual dividends paid and the fair market value of CVS Health Corporation stock at the grant date.
(2) The expected volatility is estimated based on the historical volatility of CVS Health Corporation's daily stock price over the previous six-month period.
(3) The risk-free interest rate is selected based on the Treasury constant maturity interest rate whose term is consistent with the expected term of ESPP purchases (i.e., six months).
(4) The expected life is based on the semi-annual purchase period.

14. Shareholders' Equity

Share Repurchase Programs

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

In billions **Authorization Date**	Authorized	Remaining as of December 31, 2025
November 17, 2022 ("2022 Repurchase Program")	$ 10.0	$ 10.0
December 9, 2021 ("2021 Repurchase Program")	10.0	1.5

Each of the share Repurchase Programs was effective immediately and 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. Both the 2022 and 2021 Repurchase Programs can be modified or terminated by the Board at any time.

During the year ended December 31, 2025, the Company did not repurchase any shares of its common stock. During the years ended December 31, 2024 and 2023, the Company repurchased an aggregate of 39.7 million shares of common stock for approximately $3.0 billion and an aggregate of 22.8 million shares of common stock for approximately $2.0 billion, respectively, each pursuant to the 2021 Repurchase Program. This activity includes the share repurchases under the ASR transactions described below.

Pursuant to the authorization under the 2021 Repurchase Program, the Company entered into a $3.0 billion fixed dollar ASR with Morgan Stanley & Co. LLC. Upon payment of the $3.0 billion purchase price on January 4, 2024, the Company received a number of shares of CVS Health Corporation's common stock equal to 85% of the $3.0 billion notional amount of the ASR or approximately 31.4 million shares, which were placed into treasury stock in January 2024. The ASR was accounted for as an initial treasury stock transaction for $2.6 billion and a forward contract for $0.4 billion. The forward contract was classified as an equity instrument and was recorded within capital surplus. In March 2024, the Company received approximately 8.3 million shares of CVS Health Corporation's common stock, representing the remaining 15% of the $3.0 billion notional amount of the ASR, thereby concluding the ASR. These shares were placed into treasury and the forward contract was reclassified from capital surplus to treasury stock in March 2024.

Pursuant to the authorization under the 2021 Repurchase Program, the Company entered into a $2.0 billion fixed dollar ASR with Citibank, N.A. Upon payment of the $2.0 billion purchase price on January 4, 2023, the Company received a number of shares of CVS Health Corporation's common stock equal to 80% of the $2.0 billion notional amount of the ASR or approximately 17.4 million shares, which were placed into treasury stock in January 2023. The ASR was accounted for as an

initial treasury stock transaction for $1.6 billion and a forward contract for $0.4 billion. The forward contract was classified as an equity instrument and was recorded within capital surplus. In February 2023, the Company received approximately 5.4 million shares of CVS Health Corporation's common stock, representing the remaining 20% of the $2.0 billion notional amount of the ASR, thereby concluding the ASR. These shares were placed into treasury stock and the forward contract was reclassified from capital surplus to treasury stock in February 2023.

At the time they were received, the initial and final receipt of shares resulted in an immediate reduction of the outstanding shares used to calculate the weighted average common shares outstanding for basic and diluted earnings per share.

Dividends

The quarterly cash dividend declared by the Board was $0.665 per share in 2025 and 2024 and $0.605 per share in 2023. CVS Health Corporation has paid cash dividends every quarter since becoming a public company. Future dividend payments will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

Regulatory Requirements

The Company's insurance business operations are conducted through subsidiaries that principally consist of health maintenance organizations ("HMOs") and insurance companies. The Company's HMO and insurance subsidiaries report their financial statements in accordance with accounting practices prescribed by state regulatory authorities which may differ from GAAP. The combined statutory net income (loss) for the years ended and estimated combined statutory and capital surplus at December 31, 2025, 2024 and 2023 for the Company's insurance and HMO subsidiaries were as follows:

In millions	**2025**	**2024**	**2023**
Statutory net income (loss)	$ 3,707	$ (1,185)	$ 2,757
Estimated statutory capital and surplus	23,505	20,085	16,961

The Company's insurance and HMO subsidiaries paid $1.5 billion of gross dividends to the Company for the year ended December 31, 2025.

In addition to general state law restrictions on payments of dividends and other distributions to stockholders applicable to all corporations, HMOs and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity and restrict the amount of dividends and other distributions that may be paid to their equity holders. In addition, in connection with the acquisition of Aetna, the Company made certain undertakings that require prior regulatory approval of dividends by certain of its HMOs and insurance companies. At December 31, 2025, these amounts were as follows:

In millions	
Estimated minimum statutory surplus required by regulators	$ 11,710
Investments on deposit with regulatory bodies	737
Estimated maximum dividend distributions permitted in 2026 without prior regulatory approval	3,788

Noncontrolling Interests

At December 31, 2025 and 2024, noncontrolling interests were $168 million and $170 million, respectively, primarily related to third party interests in the Company's operating entities. The noncontrolling entities' share is included in total shareholders' equity on the consolidated balance sheets.

15. Other Comprehensive Income

Shareholders' equity included the following activity in accumulated other comprehensive income (loss) in 2025, 2024 and 2023:

	At December 31,		
In millions	**2025**	**2024**	**2023**
Net unrealized investment gains (losses):			
Beginning of year balance	$ (399)	$ (429)	$ (1,519)
Other comprehensive income (loss) before reclassifications *($527, $(177) and $612 pretax)*	514	(170)	603
Amounts reclassified from accumulated other comprehensive loss *($98, $226 and $566 pretax)* [(1)]	91	200	487
Other comprehensive income	605	30	1,090
End of year balance	206	(399)	(429)
Change in discount rate on long-duration insurance reserves:			
Beginning of period balance	265	152	219
Other comprehensive income (loss) *($(64), $146, and $(92) pretax)*	(50)	113	(67)
Other comprehensive income (loss)	(50)	113	(67)
End of period balance	215	265	152
Foreign currency translation adjustments:			
Beginning of year balance	(4)	—	—
Other comprehensive income (loss)	11	(4)	—
Other comprehensive income (loss)	11	(4)	—
End of year balance	7	(4)	—
Net cash flow hedges:			
Beginning of year balance	229	244	239
Other comprehensive income before reclassifications *($5, $0 and $25 pretax)*	3	—	19
Amounts reclassified from accumulated other comprehensive income *($(23), $(20) and $(19) pretax)* [(2)]	(16)	(15)	(14)
Other comprehensive income (loss)	(13)	(15)	5
End of year balance	216	229	244
Pension and other postretirement benefits:			
Beginning of year balance	(211)	(264)	(203)
Other comprehensive income (loss) *($(37), $71 and $(81) pretax)*	(27)	53	(61)
Other comprehensive income (loss)	(27)	53	(61)
End of year balance	(238)	(211)	(264)
Total beginning of year accumulated other comprehensive loss	(120)	(297)	(1,264)
Total other comprehensive income	526	177	967
Total end of year accumulated other comprehensive income (loss)	$ 406	$ (120)	$ (297)

(1) Amounts reclassified from accumulated other comprehensive loss for specifically identified debt securities are included in net investment income in the consolidated statements of operations.

(2) Amounts reclassified from accumulated other comprehensive income for specifically identified cash flow hedges are included within interest expense in the consolidated statements of operations. The Company expects to reclassify $16 million, net of tax, in net gains associated with its cash flow hedges into net income within the next 12 months.

16. Earnings Per Share

Earnings per share is computed using the treasury stock method. Stock options and SARs to purchase 8 million shares of common stock were outstanding, but were excluded from the calculations of diluted earnings per share for each of the years ended December 31, 2025, 2024 and 2023 because their exercise prices were greater than the average market price of the common shares and, therefore, the effect would be antidilutive.

The following is a reconciliation of basic and diluted earnings per share for the years ended December 31, 2025, 2024 and 2023:

In millions, except per share amounts	**2025**	**2024**	**2023**
Numerator for earnings per share calculation:			
Net income attributable to CVS Health	$ 1,768	$ 4,614	$ 8,344
Denominator for earnings per share calculation:			
Weighted average shares, basic	1,267	1,259	1,285
Restricted stock units and performance stock units	3	2	3
Stock options and SARs	1	1	2
Weighted average shares, diluted	1,271	1,262	1,290
Earnings per share:			
Basic	$ 1.40	$ 3.67	$ 6.49
Diluted	$ 1.39	$ 3.66	$ 6.47

17. Reinsurance

The Company utilizes reinsurance agreements primarily to: (a) reduce required capital and (b) facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit the Company to recover a portion of its losses from reinsurers, although they do not discharge the Company's primary liability as the direct insurer of the risks reinsured.

Reinsurance recoverables (recorded as other current assets or other assets on the consolidated balance sheets) at December 31, 2025 and 2024 were as follows:

In millions	**2025**	**2024**
Reinsurer		
Hartford Life and Accident Insurance Company	$ 960	$ 1,119
Lincoln Life & Annuity Company of New York	426	444
Individual State Reinsurance Programs	148	189
Fresenius Medical Care Reinsurance Company (Cayman) Ltd.	84	75
Resolution Life Group Holdings Ltd.	32	33
All Other	54	67
Total	$ 1,704	$ 1,927

Direct, assumed and ceded premiums earned for the years ended December 31, 2025, 2024 and 2023 were as follows:

In millions	**2025**	**2024**	**2023**
Direct	$ 135,487	$ 123,629	$ 99,753
Assumed	573	471	350
Ceded	(1,309)	(1,204)	(911)
Net premiums	$ 134,751	$ 122,896	$ 99,192

The impact of reinsurance on health care costs for the years ended December 31, 2025, 2024 and 2023 was as follows:

In millions	**2025**	**2024**	**2023**
Direct	$ 126,263	$ 115,974	$ 86,738
Assumed	536	431	223
Ceded	(1,261)	(1,284)	(714)
Net health care costs	$ 125,538	$ 115,121	$ 86,247

There is not a material difference between premiums on a written basis versus an earned basis.

The Company also has various agreements with unrelated reinsurers that do not qualify for reinsurance accounting under GAAP, and consequently are accounted for using deposit accounting. The Company entered into these contracts to reduce the risk of catastrophic loss which in turn reduces the Company's capital and surplus requirements. Total deposit assets and liabilities related to reinsurance agreements that do not qualify for reinsurance accounting under GAAP were not material as of December 31, 2025 or 2024.

18. Commitments and Contingencies

Guarantees

The Company had the following significant guarantee arrangements at December 31, 2025:

- 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 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 $807 million and $857 million at December 31, 2025 and 2024, respectively. See Note 1 ''Significant Accounting Policies'' for additional information on Separate Accounts. Contract holders assume all investment and mortality risk and are required to maintain Separate Accounts balances at or above a specified level. The level of required funds is a function of the risk underlying the Separate Account's investment strategy. If contract holders do not maintain the required level of Separate Accounts assets to meet the annuity guarantees, the Company would establish an additional liability. Contract holders' balances in the Separate Accounts at December 31, 2025 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, 2025.

Lease Guarantees

Between 1995 and 1997, the Company sold or spun off a number of subsidiaries, including Linens 'n Things and Marshalls. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the former subsidiary's lease obligations for the initial lease term and any extension thereof pursuant to a renewal option provided for in the lease prior to the time of the disposition. When the subsidiaries were disposed of and accounted for as discontinued operations, the Company's guarantees remained in place, although each initial purchaser agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries fail to make the required payments under a store lease, the Company could be required to satisfy those obligations. As of December 31, 2025, the Company guaranteed 60 such store leases (excluding the lease guarantees related to Linens 'n Things, which have been recorded as a liability on the consolidated balance sheets), with the maximum remaining lease term extending through 2036.

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of

long-term care insurers and life insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA. It is reasonably possible that in the future the Company may record a liability and expense relating to insolvencies which could have a material adverse effect on the Company's operating results, financial condition and cash flows. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that limit future offsets.

HMOs in certain states in which the Company does business are subject to assessments, including market stabilization and other risk-sharing pools, for which the Company is assessed charges based on incurred claims, demographic membership mix and other factors. The Company establishes liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments the Company pays are dependent upon the Company's experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, the Company believes it has adequate reserves to cover such assessments.

Litigation and Regulatory Proceedings

The Company has been involved or is currently involved in numerous legal and regulatory proceedings, which may include claims of or relating to bad faith, medical or professional malpractice, breach of fiduciary duty, claims processing and billing, dispensing of medications, the use of medical testing devices in the in-home evaluation setting, non-compliance with state and federal regulatory regimes, marketing misconduct, denial of or failure to timely or appropriately pay or administer claims and benefits, provider network structure (including the use of performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure or use of personal information, anticompetitive practices, including antitrust violations, the Company's participation in the 340B program, general contractual matters, product liability, intellectual property litigation, discrimination 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.

The Company is also a party to government investigations, audits, reviews, claims enforcement actions and litigation. These include routine, regular and special investigations, audits, subpoenas, civil investigative demands ("CIDs") and reviews by CMS, state insurance and health and welfare departments, the U.S. Department of Justice (the "DOJ"), state Attorneys General, the U.S. Drug Enforcement Administration (the "DEA"), the U.S. Federal Trade Commission (the "FTC") and other governmental authorities.

Legal proceedings, in general, and securities, class action and multi-district litigation, in particular, and governmental special investigations, audits, reviews, litigation and enforcement proceedings can be expensive and disruptive. Some of the litigation matters may purport or be determined to be class actions, mass actions and/or involve parties seeking large and/or indeterminate amounts, including punitive or exemplary damages, and may remain unresolved for several years. The Company also may be named from time to time in *qui tam* actions initiated by private third parties that could also be separately pursued by a governmental body. The results of legal proceedings, including government investigations, are often uncertain and difficult to predict, and the costs incurred in these matters can be substantial, regardless of the outcome.

The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and reasonably estimable, the Company does not establish an accrued liability. Other than the controlled substances litigation accruals described below and as otherwise noted, none of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's consolidated balance sheets.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. The Company believes that its defenses and assertions in pending legal proceedings have merit and does not believe that any of these pending matters, after consideration of applicable reserves and rights to indemnification, will have a material adverse effect on the Company's financial position. Substantial unanticipated verdicts, fines and rulings, however, do sometimes occur, which could result in judgments against the Company, entry into settlements or a revision to its expectations regarding the outcome of certain matters, and such developments could have a material adverse effect on its results of operations. In addition, as a result of governmental investigations or proceedings, the Company may be subject to damages,

civil or criminal fines or penalties, or other sanctions including possible suspension or loss of licensure and/or exclusion from participating in government programs. The outcome of such governmental investigations of proceedings could be material to the Company.

Usual and Customary Pricing Litigation

The Company is named as a defendant in a number of lawsuits that allege that the Company's retail pharmacies overcharged for prescription drugs by not submitting the correct usual and customary price during the claims adjudication process. These actions are brought by a number of different types of plaintiffs, including private payors and government payors, and are based on different legal theories. Some of these cases are brought as putative class actions in which classes have been certified, and one of the cases asserts state false claims act claims by several state attorneys general in an intervened complaint filed in April 2025 and unsealed in May 2025. The Company is defending itself against these claims.

PBM Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning its PBM practices.

The Company is facing multiple lawsuits, including by the FTC, state Attorneys General, governmental subdivisions, private parties and several putative class actions, regarding drug pricing and its rebate arrangements with drug manufacturers. These complaints, brought by a number of different types of plaintiffs under a variety of legal theories, generally allege that rebate agreements between the drug manufacturers and PBMs caused inflated prices for certain drug products. The majority of these cases have now been transferred into a multi-district litigation in the U.S. District Court for the District of New Jersey. The Company is defending itself against these claims. The Company has also received subpoenas, CIDs, and other requests for documents and information from, and is being investigated by, the DOJ, the U.S. Department of Health and Human Services ("HHS"), the FTC and Attorneys General of several states and the District of Columbia regarding its PBM practices, including pharmacy contracting practices and reimbursement, pricing and rebates. The Company has been providing documents and information in response to these subpoenas, CIDs and requests for information. In September 2024, the FTC filed an administrative complaint against the three largest PBMs (the "PBM Group") and their affiliated group purchasing organizations, including subsidiaries of the Company. The complaint alleged that the PBM Group and their affiliated group purchasing organizations engaged in anti-competitive and unfair practices that "artificially" increased insulin costs. The Company is defending itself against the complaint, while simultaneously attempting to reach a negotiated resolution with the FTC. In November 2024, the PBM Group filed a complaint in the U.S. District Court for the Eastern District of Missouri challenging the constitutionality of the FTC's administrative complaint. After the district court denied the challenge, the PBM Group filed an appeal with the U.S. Court of Appeals for the Eighth Circuit, which is still pending.

United States ex rel. Behnke v. CVS Caremark Corporation, et al. (U.S. District Court for the Eastern District of Pennsylvania). In April 2018, the Court unsealed a complaint filed in February 2014. The government has declined to intervene in this case. The relator alleges that the Company submitted, or caused to be submitted, to Part D of the Medicare program Prescription Drug Event data and/or Direct and Indirect Remuneration reports that misrepresented true prices paid by the Company's PBM to pharmacies for drugs dispensed to Part D beneficiaries with prescription benefits administered by the Company's PBM. Following a two-week trial, the Court issued a split decision and ruled that the Company was liable under the False Claims Act as to certain claims. After trebling damages and assessing penalties, the court entered judgment for $291 million, for which the Company recorded a litigation reserve in the year ended December 31, 2025. The Company has appealed to the Third Circuit Court of Appeals.

Controlled Substances Litigation, Audits and Subpoenas

Forty-five states, the District of Columbia, and all eligible United States territories are participating in a settlement resolving substantially all opioid claims against Company entities by participating states and political subdivisions but not private plaintiffs. A high percentage of eligible subdivisions within the participating states also have elected to join the settlement. The settlement agreement is available at nationalopioidsettlement.com. The Company has separately entered into settlement agreements with four states – Florida, West Virginia, New Mexico and Nevada – and a high percentage of eligible subdivisions within those states also have elected to participate.

The final settlement agreement contains certain contingencies related to payment obligations. Because these contingencies are inherently unpredictable, the assessment requires judgments about future events. As of December 31, 2025, the Company's

remaining accrual related to these opioid litigation matters was approximately $4.0 billion. The amount of ultimate loss may differ from the amount accrued by the Company.

The State of Maryland has elected not to participate, and thus subdivisions within the State of Maryland may not participate, in the settlement. The State of Maryland has issued a civil subpoena for information from the Company, and litigation is pending with certain subdivisions within the State of Maryland as well as other non-participating subdivisions in other geographies, including the City of Philadelphia, and private parties such as hospitals and third-party payors. Trial in a case brought by a group of Florida hospitals concluded in December 2025 when the Court declared a mistrial due to a deadlocked jury; a new trial is scheduled to begin in August 2026. The Company is defending itself against the claims made in these cases.

Because of the many uncertainties associated with any settlement arrangement or other resolution of opioid-related litigation matters, and because the Company continues to actively defend ongoing litigation for which it believes it has defenses and assertions that have merit, the Company is not able to reasonably estimate the range of ultimate possible loss for all opioid-related litigation matters at this time. The outcome of these legal matters could have a material effect on the Company's business, financial condition, operating results and/or cash flows.

In December 2024, the DOJ intervened in a previously sealed *qui tam* action and filed an amended complaint in the U.S. District Court for the District of Rhode Island, alleging, among other claims, violations of the federal Controlled Substances Act and the federal False Claims Act based on the filling of opioid and other controlled substance prescriptions at CVS Pharmacy locations nationwide. The Company is defending itself against the claims made in this case. Separately, the Company has been served with subpoenas issued by the U.S. Attorney's Office for the Western District of Virginia, seeking records related to, among other things, commercial arrangements between the Company's PBM and opioid manufacturers.

Prescription Processing Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning its prescription processing practices, including related to billing government payors for prescriptions, and the following:

U.S. ex rel. *Bassan* et al. *v. Omnicare, Inc. and CVS Health Corp.* (U.S. District Court for the Southern District of New York). In December 2019, the U.S. Attorney's Office for the Southern District of New York filed a complaint-in-intervention in this previously sealed *qui tam* case. The complaint alleges that for certain non-skilled nursing facilities, Omnicare improperly filled prescriptions where a valid prescription did not exist and that these dispensing events violated the federal False Claims Act. In April 2025, the jury found both Omnicare and CVS Health Corporation liable. The jury awarded approximately $136 million due to Omnicare's conduct. This amount is automatically required to be tripled by statute to approximately $407 million. Accordingly, a litigation reserve was recorded related to this matter in the three months ended March 31, 2025. The jury found no damages attributable to CVS Health Corporation. In July 2025, the Court awarded penalties against Omnicare for $542 million, for which the Company recorded an incremental litigation reserve in the three months ended June 30, 2025. The Court also found CVS Health Corporation to be jointly and severally liable for $165 million of the $542 million in penalties. The Company has filed an appeal to the Second Circuit. As discussed in Note 1 ''Significant Accounting Policies'', on September 22, 2025, Omnicare initiated a voluntary court-supervised Chapter 11 bankruptcy process and was deconsolidated in the three months ended September 30, 2025. The litigation reserve of $165 million that CVS Health Corporation was jointly and severally liable for remained as a liability on the consolidated balance sheet at December 31, 2025.

U.S. ex rel. Gill et al. v. CVS Health Corp. et al. (U.S. District Court for the Northern District of Illinois). In July 2022, the Delaware Attorney General's Office moved for partial intervention as to allegations under the Delaware false claims act related to not escheating alleged overpayments in this previously sealed *qui tam* case. The federal government and the remaining states declined to intervene on other additional theories in the relator's complaint, except that the federal government filed a notice of intervention for the limited purpose of defending the constitutionality of the *qui tam* provisions of the False Claims Act. The Company is defending itself against all of the claims.

Provider Proceedings

The Company is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by providers with whom the Company has a contract and with whom the Company does not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that the Company paid too little to its health plan members and/or providers for out-of-network services (including COVID-19 testing) 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).

The Company also has received subpoenas and/or requests for documents and other information from, and been investigated by, the DOJ, state Attorneys General and other state and/or federal regulators, legislators and agencies relating to claims payments, and the Company is involved in other litigation regarding its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against the Company with respect to its out-of-network benefit payment and/or administration practices.

CMS Actions

CMS regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to the Company's and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by providers. The Company collects claim and encounter data from providers and generally relies on providers to appropriately code their submissions to the Company and document their medical records, including the diagnosis data submitted to the Company with claims. CMS pays increased premiums to Medicare Advantage plans and Medicare PDP plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to the Company. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including the Company's plans, to validate coding practices and supporting medical record documentation maintained by providers and the resulting risk-adjusted premium payments to the plans. CMS may require the Company to refund premium payments if the Company's risk-adjusted premiums are not properly supported by medical record data. The Office of the Inspector General of the U.S. Department of Health and Human Services (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. CMS has announced its intention to audit all contracts as a standard practice. CMS' auditing methodology is subject to pending litigation, so the Company is not able to determine the methodology, and potential extrapolation, that would be used for future audits.

Medicare and Medicaid Litigation and Investigations

The Company has received CIDs from the Civil Division of the DOJ in connection with investigations of the Company's identification and/or submission of diagnosis codes related to risk adjustment payments, including patient chart review processes, under Parts C and D of the Medicare program. The Company is cooperating with the government and providing documents and information in response to these CIDs.

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.

U.S. ex rel. Andrew Shea v. Aetna Life Insurance Company, et al. (U.S. District Court for the District of Massachusetts). In May 2025, the U.S. Attorney's Office for the District of Massachusetts filed a complaint-in-intervention in this previously sealed *qui tam* case. The complaint alleges that the Company and two other large health insurance companies, paid kickbacks to insurance brokers to induce them to direct patients to their Medicare Advantage plans and, as a result, claims made to the government in connection with those plans violated the federal False Claims Act and Anti-Kickback Statute. The complaint also alleges that the Company engaged in discriminatory conduct. The Company is defending itself against these claims.

In addition, awards to the Company and others of certain government contracts, particularly Medicaid contracts and other contracts with government customers in the Company's Health Care Benefits segment, frequently are subject to protests by unsuccessful bidders. These protests may result in awards to the Company being reversed, delayed, or modified. The loss or delay in implementation of any government contract could adversely affect the Company's operating results. The Company will continue to defend contract awards it receives.

Stockholder Matters

The Company has received several demands for inspection of books and records pursuant to Delaware General Corporation Law Section 220 ("Section 220 demands"). Section 220 demands generally relate to potential breaches of fiduciary duties by the Board in relation to its oversight of certain matters, such as opioids and PBM and retail practices. While responding to

Section 220 demands may consume Company resources, Section 220 demands themselves are not material to the Company unless they lead to formal complaints or legal actions.

Beginning in February 2019, multiple class action complaints, as well as a derivative complaint, were filed by putative plaintiffs against the Company and certain current and former officers and directors. The plaintiffs in these cases assert a variety of causes of action under federal securities laws that are premised on allegations that the defendants made certain omissions and misrepresentations relating to the performance of the Company's former LTC business unit. Since filing, several of the cases have been consolidated, and three have resolved. In February 2025, the District of Rhode Island granted the Company's motion to dismiss *In re CVS Health Corp. Securities Act Litigation* (formerly known as *Waterford*) and in March 2025 plaintiffs filed a notice of appeal of that decision to the First Circuit. A derivative case in the District of Rhode Island, *Lovoi v. Aguirre*, had been stayed pending the outcome of the *Waterford* case, and will remain stayed pending the resolution of the appeal. The Company and its current and former officers and directors are defending themselves against remaining claims.

Beginning in July 2024, two purported class action complaints, as well as multiple derivative complaints, were filed by putative plaintiffs against the Company and certain current and former officers and directors. The plaintiffs in these cases assert a variety of causes of action under federal securities laws and state law that are premised on allegations that the defendants made certain omissions and misrepresentations relating to the profitability of the Health Care Benefits segment. Two purported class actions were filed and have been consolidated in U.S. District Court for the Southern District of New York. In May 2025, the defendants filed a motion to dismiss the amended consolidated class action complaint captioned as *Louisiana Sheriffs' Pension and Relief Fund, et al. v. CVS Health Corp., et al.* Two derivative cases were also filed in the Southern District of New York and have been consolidated as *In re CVS Health Corporation Derivative Litigation*. Two derivative cases filed in the District of Rhode Island have been consolidated as *In re CVS Health Corporation Stockholder Derivative Litigation*. The consolidated derivative actions have been stayed pending the outcome of any motion to dismiss in the consolidated *Louisiana Sheriffs'* securities class action. Three additional derivative cases were filed in Rhode Island Superior Court: two have been consolidated as *In re CVS Health Corporation Stockholder Derivative Litigation* and the third is *Davidow v. Lynch, et al*., and these cases have also been stayed on similar terms as the other actions. The Company and the individual defendants are defending themselves against these claims. In January 2025, the Board received a stockholder demand containing allegations substantially similar to those made in the class action and derivative matters, and requesting that it take certain actions, including investigating whether any Board members or officers breached their fiduciary duties related to those allegations, and bringing litigation to recover the Company's damages if any such misconduct is found. The Board has determined to defer a decision on the demand pending developments in the related litigation.

19. Segment Reporting

The Company has four reportable segments: Health Care Benefits, Health Services, Pharmacy & Consumer Wellness and Corporate/Other. The Company's segments maintain separate financial information, and the CODM, the Company's Chief Executive Officer, evaluates the segments' operating results on a regular basis in deciding how to allocate resources among the segments and in assessing segment performance. The CODM evaluates the performance of the Company's segments based on adjusted operating income. Total assets by segment are not used by the CODM to assess the performance of, or allocate resources to, the Company's segments, therefore total assets by segment are not disclosed.

Adjusted operating income (loss) is defined as operating income (loss) (GAAP measure) excluding the impact of amortization of intangible assets, net realized capital gains or losses, and other items, if any, that neither relate to the ordinary course of the Company's business nor reflect the Company's underlying business performance. The CODM uses adjusted operating income as its principal measure of segment performance as it enhances the CODM's ability to compare past financial performance with current performance and analyze underlying business performance and trends. Non-GAAP financial measures the Company discloses, such as consolidated adjusted operating income, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

In 2025, 2024 and 2023, revenues from the federal government accounted for 25%, 24% and 19%, respectively, of the Company's consolidated total revenues, primarily related to contracts with CMS for coverage of Medicare-eligible individuals within the Health Care Benefits segment.

The following are reconciliations of financial measures of the Company's segments to the consolidated totals:

	Year Ended December 31, 2025				
In millions	**Health Care Benefits**	**Health Services [1]**	**Pharmacy & Consumer Wellness**	**Corporate/ Other**	**Consolidated Totals**
Revenues from external customers	$ 141,454	$ 164,603	$ 93,724	$ 53	$ 399,834
Intersegment revenues	118	25,802	45,643	—	71,563
Net investment income	1,782	20	—	431	2,233
Total revenues	143,354	190,425	139,367	484	473,630
Intersegment eliminations [2]					(71,563)
Total consolidated revenues					$ 402,067
Less: Net realized capital gains (losses)	13	25	—	(82)	
Cost of products sold	—	175,634	113,583	—	
Health care costs	122,949	4,834	—	177	
Other segment items [3]	17,453	2,781	19,744	2,076	
Adjusted operating income (loss)	$ 2,939	$ 7,151	$ 6,040	$ (1,687)	$ 14,443
Reconciliation of principal measure of segment performance to consolidated operating income:					
Amortization of intangible assets [4]					1,976
Net realized capital losses [5]					44
Acquisition-related integration costs [6]					117
Goodwill impairment [7]					5,725
Health Care Delivery clinic closure charge [8]					83
Opioid litigation charge [9]					320
Office real estate optimization charges [10]					10
Legacy litigation charges [11]					1,220
Loss on Accountable Care assets [12]					288
Operating income (GAAP measure)					4,660
Gain on deconsolidation of subsidiary [13]					483
Interest expense					(3,119)
Other income					112
Income before income tax provision					$ 2,136
Depreciation and amortization	$ 1,579	$ 1,039	$ 1,573	$ 415	$ 4,606

In millions	Year Ended December 31, 2024				
	Health Care Benefits	Health Services [1]	Pharmacy & Consumer Wellness	Corporate/ Other	Consolidated Totals
Revenues from external customers	$ 129,120	$ 158,016	$ 83,464	$ 56	$ 370,656
Intersegment revenues	72	15,304	41,036	—	56,412
Net investment income	1,473	285	—	395	2,153
Total revenues	130,665	173,605	124,500	451	429,221
Intersegment eliminations [2]					(56,412)
Total consolidated revenues					$ 372,809
Less: Net realized capital gains (losses)	(97)	289	—	(75)	
Cost of products sold	—	160,036	99,337	—	
Health care costs	113,659	3,407	—	187	
Other segment items [3]	16,796	2,630	19,389	1,687	
Adjusted operating income (loss)	$ 307	$ 7,243	$ 5,774	$ (1,348)	$ 11,976
Reconciliation of principal measure of segment performance to consolidated operating income:					
Amortization of intangible assets [4]					2,025
Net realized capital gains [5]					(117)
Acquisition-related integration costs [6]					243
Opioid litigation charge [9]					100
Office real estate optimization charges [10]					30
Restructuring charges [14]					1,179
Operating income (GAAP measure)					8,516
Interest expense					(2,958)
Gain on early extinguishment of debt [16]					491
Other income					99
Income before income tax provision					$ 6,148
Depreciation and amortization	$ 1,599	$ 1,059	$ 1,543	$ 396	$ 4,597

In millions	Year Ended December 31, 2023				
	Health Care Benefits	Health Services [1]	Pharmacy & Consumer Wellness	Corporate/ Other	Consolidated Totals
Revenues from external customers	$ 104,800	$ 174,018	$ 77,748	$ 57	$ 356,623
Intersegment revenues	81	12,826	39,020	—	51,927
Net investment income (loss)	765	(1)	(5)	394	1,153
Total revenues	105,646	186,843	116,763	451	409,703
Intersegment eliminations [2]					(51,927)
Total consolidated revenues					$ 357,776
Less: Net realized capital losses	(402)	—	(5)	(90)	
Cost of products sold	—	175,424	91,447	1	
Health care costs	85,504	1,607	—	210	
Other segment items [3]	14,967	2,500	19,358	1,648	
Adjusted operating income (loss)	$ 5,577	$ 7,312	$ 5,963	$ (1,318)	$ 17,534
Reconciliation of principal measure of segment performance to consolidated operating income:					
Amortization of intangible assets [4]					1,905
Net realized capital losses [5]					497
Acquisition-related transaction and integration costs [6]					487
Office real estate optimization charges [10]					46
Restructuring charges [14]					507
Loss on assets held for sale [15]					349
Operating income (GAAP measure)					13,743
Interest expense					(2,658)
Other income					88
Income before income tax provision					$ 11,173
Depreciation and amortization	$ 1,572	$ 880	$ 1,549	$ 365	$ 4,366

(1) Total revenues of the Health Services segment include approximately $10.9 billion, $11.4 billion and $13.7 billion of retail co-payments for 2025, 2024 and 2023, respectively. See Note 1 ‘‘Significant Accounting Policies’’ for additional information about retail co-payments.

(2) Intersegment revenue eliminations relate to intersegment revenue generating activities that occur between the Health Care Benefits segment, the Health Services segment, and/or the Pharmacy & Consumer Wellness segment.

(3) Other segment items for each reportable segment includes operating expenses, which primarily consists of selling, general and administrative expenses. Other segment items excludes the impact of amortization of intangible assets and other items, if any, that neither relate to the ordinary course of the Company’s business nor reflect the Company’s underlying business performance.

(4) The Company’s acquisition activities have resulted in the recognition of intangible assets as required under the acquisition method of accounting which consist primarily of trademarks, customer contracts/relationships, covenants not to compete, technology, provider networks and value of business acquired. Definite-lived intangible assets are amortized over their estimated useful lives and are tested for impairment when events indicate that the carrying value may not be recoverable. The amortization of intangible assets is reflected in operating expenses within each segment. Although intangible assets contribute to the Company’s revenue generation, the amortization of intangible assets does not directly relate to the underwriting of the Company’s insurance products, the services performed for the Company’s customers or the sale of the Company’s products or services. Additionally, intangible asset amortization expense typically fluctuates based on the size and timing of the Company’s acquisition activity. Accordingly, the Company believes excluding the amortization of intangible assets enhances the Company’s and investors’ ability to compare the Company’s past financial performance with its current performance and to analyze underlying business performance and trends. Intangible asset amortization excluded from the related non-GAAP financial measure represents the entire amount recorded within the Company’s GAAP financial statements, and the revenue generated by the associated intangible assets has not been excluded from the related non-GAAP financial measure. Intangible asset amortization is excluded from the related non-GAAP financial measure because the amortization, unlike the related revenue, is not affected by operations of any particular period unless an intangible asset becomes impaired or the estimated useful life of an intangible asset is revised.

(5) The Company’s net realized capital gains and losses arise from various types of transactions, primarily in the course of managing a portfolio of assets that support the payment of insurance liabilities. Net realized capital gains and losses are reflected in net investment income (loss) within each segment. These capital gains and losses are the result of investment decisions, market conditions and other economic developments that are unrelated to the performance of the Company’s business, and the amount and timing of these capital gains and losses do not directly relate to the underwriting of the Company’s insurance products, the services performed for the Company’s customers or the sale of the Company’s products or services. Accordingly, the Company

believes excluding net realized capital gains and losses enhances the Company's and investors' ability to compare the Company's past financial performance with its current performance and to analyze underlying business performance and trends.

(6) In 2025 and 2024, the acquisition-related integration costs relate to the acquisitions of Signify Health and Oak Street Health. In 2023, the acquisition-related transaction and integration costs relate to the acquisitions of Signify Health and Oak Street Health. The acquisition-related transaction and integration costs are reflected in operating expenses within the Corporate/Other segment.

(7) In 2025, the goodwill impairment charge relates to the Health Care Delivery reporting unit within the Health Services segment.

(8) In 2025, the Health Care Delivery clinic closure charge primarily relates to the write down of long-lived assets in connection with the planned closure of certain existing Oak Street Health clinics in 2026, as well as associated severance and employee-related costs expected to be incurred. The Health Care Delivery clinic closure charge is reflected in operating expenses within the Health Services segment.

(9) In 2025 and 2024, the opioid litigation charges relate to changes in the Company's accrual related to ongoing opioid litigation matters.

(10) In 2025, 2024 and 2023, the office real estate optimization charges primarily relate to the abandonment of leased real estate and the related right-of-use assets and property and equipment in connection with the Company's evaluation of corporate office real estate space in response to its ongoing flexible work arrangement. The office real estate optimization charges are reflected in operating expenses within each segment.

(11) In 2025, the Company recorded legacy litigation charges related to two court decisions associated with its past business practices.

In April 2025, a jury found Omnicare and CVS Health Corporation liable in connection with alleged violations of the federal False Claims Act related to dispensing practices by Omnicare from 2010, prior to its acquisition by the Company in 2015, through 2018. Damages were found only with respect to Omnicare. Accordingly, the Company recorded a litigation charge of $387 million during the first quarter of 2025. During the second quarter of 2025, the Company recorded a charge of $542 million, reflecting penalties assessed under the False Claims Act. These litigation charges are reflected in operating expenses within the Pharmacy & Consumer Wellness segment.

In June 2025, a court found certain subsidiaries of CVS Health Corporation liable for damages in connection with a complaint filed in February 2014, in which the government declined to intervene, related to PBM direct and indirect remuneration reporting practices for two clients from 2010 through 2016, which the Company has since modified. In connection with this court decision, the Company recorded a litigation charge of $291 million during the second quarter of 2025. This litigation charge is reflected in operating expenses within the Health Services segment.

(12) In 2025, the loss on the wind down and sale of Accountable Care assets represents the pre-tax loss on the divestiture of the Company's MSSP operations, which the Company sold in March 2025, as well as costs incurred in connection with the process of winding down the Company's ACO REACH operations. The loss on Accountable Care assets is reflected in operating expenses within the Health Services segment.

(13) In 2025, the gain on deconsolidation of subsidiary relates to Omnicare, a wholly-owned indirect subsidiary of CVS Health Corporation, and certain of its subsidiary entities. In September 2025, the Omnicare Entities voluntarily initiated Chapter 11 proceedings under the U.S. Bankruptcy Code, at which time the Company determined that it no longer retained control of the Omnicare Entities and deconsolidated the subsidiaries.

(14) In 2024, the restructuring charges are primarily comprised of a store impairment charge, corporate workforce optimization costs, including severance and employee-related costs, other asset impairment and related charges associated with the discontinuation of certain non-core assets, and a stock-based compensation charge. During the third quarter of 2024, the Company finalized an enterprise-wide restructuring plan intended to streamline and simplify the organization, improve efficiency and reduce costs. In connection with this restructuring plan, the Company completed a strategic review of its retail business and determined that it planned to close additional retail stores in 2025, and, accordingly, it recorded a store impairment charge to write down the associated lease right-of-use assets and property and equipment. In addition, during the third quarter of 2024, the Company also conducted a review of its various strategic assets and determined that it would discontinue the use of certain non-core assets, at which time impairment losses were recorded to write down the carrying value of these assets to the Company's best estimate of their fair value. In 2023, the restructuring charges are primarily comprised of severance and employee-related costs, asset impairment charges and a stock-based compensation charge. The restructuring charges associated with the store impairments are reflected within the Pharmacy & Consumer Wellness segment, other asset impairments and related charges are reflected within the Corporate/Other and Pharmacy & Consumer Wellness segments and corporate workforce optimization costs, including severance and employee-related costs, as well as the stock-based compensation charge, are reflected within the Corporate/Other segment.

(15) In 2023, the loss on assets held for sale relates to the LTC business, which was included within the Pharmacy & Consumer Wellness segment prior to the deconsolidation of the Omnicare Entities in September 2025. During 2022, the Company determined that its LTC business was no longer a strategic asset and committed to a plan to sell it, at which time the LTC business met the criteria for held-for-sale accounting and its net assets were accounted for as assets held for sale. During the first quarter of 2023, a loss on assets held for sale was recorded to write down the carrying value of the LTC business to the Company's best estimate of the ultimate selling price which reflected its estimated fair value less costs to sell. As of the third quarter of 2023, the Company determined the LTC business no longer met the criteria for held-for-sale accounting and, at that time, the net assets associated with the LTC business were reclassified to held and used at their respective fair values.

(16) In 2024, the gain on early extinguishment of debt relates to the Company's repayment of approximately $2.6 billion of its outstanding senior notes in December 2024, pursuant to its tender offer for such senior notes.

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, 2025, 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, 2025, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the 2025 consolidated financial statements of the Company and our report dated February 10, 2026 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 10, 2026

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, 2025 and 2024, the related consolidated statements of operations, comprehensive income, shareholders' equity and cash flows for each of the three years in the period ended December 31, 2025, 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, 2025 and 2024, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2025, 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, 2025, 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 10, 2026 expressed an unqualified opinion thereon.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

Critical Audit Matter

The critical audit matter communicated below is a matter arising from the current period audit of the financial statements that was communicated or required to be communicated to the audit committee and that: (1) relates to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective or complex judgments. The communication of the critical audit matter does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matter below, providing a separate opinion on the critical audit matter or on the account or disclosure to which it relates.

Valuation of health care costs payable

Description of the Matter

At December 31, 2025, the incurred but not reported liabilities within the Health Care Benefits segment represented a significant portion of the health care costs payable. As discussed in Note 1 to the consolidated financial statements, the Company's liability for health care costs payable includes estimated payments for (1) services rendered to members but not yet reported and (2) claims that have been reported but not yet paid, each as of the financial statement date (collectively, "IBNR"). The estimated IBNR liability is developed utilizing actuarial principles and assumptions that include historical and projected claim submission and processing patterns, historical and assumed medical cost trends, historical utilization of medical services, claim inventory levels, changes in membership and product mix, seasonality and other relevant factors to record the actuarial best estimate of health care costs payable. There is significant uncertainty inherent in determining management's actuarial best estimate of health care costs payable. In particular, the estimate is sensitive to the assumed completion factors and the assumed health care cost trend rates.

Auditing management's actuarial best estimate of IBNR reserves for health care costs payable within the Health Care Benefits segment involved a high degree of subjectivity in evaluating management's assumptions used in the valuation process.

How We Addressed the Matter in Our Audit

We obtained an understanding, evaluated the design and tested the operating effectiveness of controls over the process for estimating IBNR reserves. This included, among others, controls over the completeness and accuracy of data used in the actuarial projections, the transfer of data between underlying source systems, and the review and approval processes that management has in place for the actuarial principles and assumptions used in estimating the health care costs payable.

To test IBNR reserves, our audit procedures included, among others, testing the completeness and accuracy of the underlying claim and membership data used in the calculation of IBNR reserves. We involved actuarial specialists to assist with our audit procedures, which included, among others, evaluating the methodologies applied by the Company in determining the actuarially determined liability, evaluating management's actuarial principles and assumptions used in their analysis based on historical claim experience, and independently calculating a range of reserve estimates for comparison to management's actuarial best estimate of the liability for health care costs payable. Additionally, we performed a review of the prior period liabilities for incurred but not paid claims to subsequent claims development.

/s/ Ernst & Young LLP

We have served as the Company's auditor since 2007.

Boston, Massachusetts
February 10, 2026

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, 2025, have concluded that as of such date the Company's disclosure controls and procedures were adequate and effective at a reasonable assurance level and designed to ensure that material information relating to the Company and its consolidated subsidiaries would be made known to such officers on a timely basis.

Management's report on internal control over financial reporting

Management is responsible for establishing and maintaining adequate internal control over financial reporting. The Company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of the Company's consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the Company's assets that could have a material effect on the Company's consolidated financial statements. In order to ensure the Company's internal control over financial reporting is effective, management regularly assesses such control and did so most recently for its financial reporting as of December 31, 2025.

Management conducted an assessment of the effectiveness of the Company's internal control over financial reporting based on the criteria established in *Internal Control-Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 Framework). This evaluation included review of the documentation, evaluation of the design effectiveness and testing of the operating effectiveness of controls. The Company s system of internal control over financial reporting is enhanced by periodic reviews by the Company's internal auditors, written policies and procedures and a written Code of Conduct adopted by CVS Health Corporation's Board of Directors, applicable to all employees of the Company. In addition, the Company has an internal Disclosure Committee, comprised of management from each functional area within the Company, which performs a separate review of disclosure controls and procedures. There are inherent limitations in the effectiveness of any system of internal control over financial reporting.

Based on management's assessment, management concluded that the Company's internal control over financial reporting is effective and provides reasonable assurance that assets are safeguarded and that the financial records are reliable for preparing financial statements as of December 31, 2025.

Ernst & Young LLP, the Company's independent registered public accounting firm, is appointed by CVS Health Corporation's Board of Directors and ratified by CVS Health Corporation's stockholders. They were engaged to render an opinion regarding the fair presentation of the Company's consolidated financial statements as well as conducting an audit of internal control over financial reporting. Their reports included in Item 8 of this Form 10-K are based upon audits conducted in accordance with the standards of the Public Company Accounting Oversight Board (United States).

Changes in internal control over financial reporting

There has been no change in the Company's internal control over financial reporting identified in connection with the evaluation required by paragraph (d) of Rule 13a-15 or Rule 15d-15 that occurred during the fourth quarter ended December 31, 2025 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, 2025 that would require disclosure under this item.

Securities Trading Plans of Directors and Executive Officers

During the year ended December 31, 2025, none of our directors or executive officers adopted or terminated any contract, instruction or written plan for the purchase or sale of CVS Health Corporation securities that was intended to satisfy the affirmative defense conditions of Rule 10b5-1(c) or any "non-Rule 10b5-1 trading arrangement."

Item 9C. Disclosure Regarding Foreign Jurisdictions that Prevent Inspections.

None.

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

Information concerning the Executive Officers of CVS Health Corporation is included in Part I of this 10-K pursuant to General Instruction G to Form 10-K.

We have adopted an insider trading policy related to the purchase, sale and other transactions in our securities entered into by our directors, officers, employees and related other persons and by us. The insider trading policy is designed to promote compliance with the securities laws and related rules and regulations, NYSE listing standards and our own Code of Conduct. Our insider trading policy is filed as Exhibit 19.1 to this 10-K.

The sections of the Proxy Statement under the captions "Committees of the Board as of the Annual Meeting," "Code of Conduct," "Audit Committee Report," and "Biographies of our Incumbent Board Nominees" are incorporated herein by reference.

Item 11. Executive Compensation.

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

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

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

The following table summarizes information about the registrant's common stock that may be issued upon the exercise of options, warrants and rights under all of the Company's equity compensation plans as of December 31, 2025:

In thousands, except weighted average exercise price	**Number of securities to be issued upon exercise of outstanding options, warrants and rights [1] (a)**	**Weighted average exercise price of outstanding options, warrants and rights (b)**	**Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in first column) (c)**
Equity compensation plans approved by stockholders [2]	28,026	$ 73.90	27,081
Equity compensation plans not approved by stockholders	1,404[3]	52.46	—
Total	29,430	$ 72.05	27,081

(1) Consists of: (i) 10.0 million shares of common stock underlying outstanding options, (ii) 0.1 million shares of common stock issuable upon the exercise of outstanding stock appreciation rights ("SARs") and (iii) 19.3 million shares of common stock issuable on the vesting of outstanding restricted stock units, performance stock units, assuming target level performance in the case of performance stock units, and deferred stock units. The number of shares included with respect to outstanding SARs is the number of shares of CVS Health Corporation common stock that would have been issued had the SARs been exercised based on the closing price per share of CVS Health Corporation common stock on December 31, 2025, as reported on the NYSE, which was $79.36.

(2) Consists of the CVS Health 2017 Incentive Compensation Plan.
(3) Consists of shares of common stock underlying outstanding equity awards pursuant to equity compensation plans not approved by stockholders, including the Amended Aetna Inc. 2010 Stock Incentive Plan (the "Aetna Plan"), the Oak Street Health, Inc. Omnibus Incentive Plan (the "Oak Street Health Plan"), the Oak Street Health, Inc. Omnibus Incentive Plan, as amended (the "Amended Oak Street Health Plan"), the Signify Health, Inc. 2021 Long-Term Incentive Plan (the "Signify Plan") and the Signify Health, Inc. 2021 Long-Term Incentive Plan, as amended (the "Amended Signify Plan").

The Company elected to continue to grant awards under the Aetna Plan to employees of Aetna and its subsidiaries following the completion of the Company's acquisition of Aetna. The Aetna Plan was designed to promote Aetna'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 and providing compensation opportunities dependent upon the Company's performance. The Aetna Plan was not submitted to the Company's stockholders and expired on May 21, 2020. Under the Aetna Plan, eligible participants could be granted stock options to purchase shares of CVS Health Corporation common stock, SARs, time-vesting and/or performance-vesting incentive stock or incentive units and other stock-based awards.

The Oak Street Plan and the Signify Plan were each approved by their respective company stockholders prior to their acquisition by CVS Health and have not been approved by the Company's stockholders. The purpose of the Oak Street Plan was to enhance the profitability and value of Oak Street Health for the benefit of its stockholders by enabling it to offer eligible individuals stock- and cash-based incentives in order to attract, retain, and reward such individuals and strengthen the mutuality of interests between such individuals and stockholders. Under the Oak Street Plan, eligible participants could be granted time-based restricted stock units and awards. The purpose of the Signify Plan was to motivate and reward employees and other individuals to perform at the highest level and contribute significantly to the success of Signify Health, thereby furthering the best interests of its stockholders. Under the Signify Plan, eligible participants could be granted stock options to purchase shares of CVS Health Corporation common stock and time-based restricted stock units.

The Company elected to continue to grant awards under the Oak Street Plan and the Signify Plan until July 28, 2023, when the Amended Oak Street Plan and the Amended Signify Plan became effective. The Amended Oak Street Plan and the Amended Signify Plan, while not approved by the Company's stockholders, have terms consistent with those of the CVS Health 2017 Incentive Compensation Plan. The Amended Oak Street Plan and the Amended Signify Plan expired on May 16, 2024, and no further shares may be granted under the terms thereof.

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

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

Item 14. Principal Accountant Fees and Services.

The section of the Proxy Statement under the caption "Item 2: Ratification of Appointment of Independent Registered Public Accounting Firm for 2026" is incorporated herein by reference.

PART IV

Item 15. Exhibits, Financial Statement Schedules.

The following documents are filed as part of this 10-K:

1. Financial Statements. See "Index to Consolidated Financial Statements" in Item 8 of this 10-K.

2. Financial Statement Schedules. All financial statement schedules are omitted because they are not applicable, not required under the instructions, or the information is included in the consolidated financial statements or related notes.

3. Exhibits. The exhibits listed in the "Index to Exhibits" in this Item 15 are filed or incorporated by reference as part of this 10-K. Exhibits marked with an asterisk (*) are management contracts or compensatory plans or arrangements. Exhibits other than those listed are omitted because they are not required to be listed or are not applicable. Pursuant to Item 601(b)(4)(iii) of Regulation S-K, the Registrant hereby agrees to furnish to the Securities and Exchange Commission a copy of any omitted instrument that is not required to be listed.

INDEX TO EXHIBITS

Exhibit	Description
3	**Articles of Incorporation and Bylaws**
3.1	Restated Certificate of Incorporation of the Registrant dated June 4, 2018 (incorporated by reference to Exhibit 3.1C of Registrant's Current Report on Form 8-K filed June 5, 2018).
3.2	By-Laws of the Registrant, as amended and restated November 17, 2022 (incorporated by reference to Exhibit 3.1 to the Registrant's Current Report on Form 8-K filed November 21, 2022).
4	**Instruments defining the rights of security holders, including indentures**
4.1	Specimen common stock certificate (incorporated by reference to Exhibit 4.1 to the Registration Statement of the Registrant ((then known as CVS Corporation) as successor to Melville Corporation) on Form 8-B filed November 4, 1996).
4.2	Senior Indenture dated August 15, 2006, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed August 15, 2006).
4.3	Subordinated Indenture, dated as of May 25, 2007, between the Registrant and The Bank of New York Mellon Trust Company, N.A. (as successor to The Bank of New York Trust Company, N.A.) (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K Filed December 10, 2024).
4.4	Second Supplemental Indenture, dated as of December 10, 2024, between the Registrant and the Bank of New York Mellon Trust Company, N.A. (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K Filed December 10, 2024).
4.5	Third Supplemental Indenture, dated as of December 10, 2024, between the Registrant and the Bank of New York Mellon Trust Company, N.A. (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K Filed December 10, 2024).
4.6	Form of the Registrant's 2028 Note (incorporated by reference to Exhibit 4.7 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.7	Form of the Registrant's 2038 Note (incorporated by reference to Exhibit 4.8 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.8	Form of the Registrant's 2048 Note (incorporated by reference to Exhibit 4.9 to the Registrant's Current Report on Form 8-K filed March 12, 2018).
4.9	Form of the Registrant's 2026 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed August 15, 2019).
4.10	Form of the Registrant's 2029 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed August 15, 2019).
4.11	Form of the Registrant's 2027 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).
4.12	Form of the Registrant's 2030 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).
4.13	Form of the Registrant's 2040 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).
4.14	Form of the Registrant's 2050 Note (incorporated by reference to Exhibit 4.4 to the Registrant's Current Report on Form 8-K filed on March 31, 2020).

4.15	Form of the Registrant's 2027 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed on August 21, 2020).
4.16	Form of the Registrant's 2030 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed on August 21, 2020).
4.17	Form of the Registrant's 2040 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed on August 21, 2020).
4.18	Form of the Registrant's 2027 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed on December 16, 2020).
4.19	Form of the Registrant's 2031 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed on December 16, 2020).
4.20	Form of the Registrant's 2031 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed on August 18, 2021).
4.21	Form of the Registrant's 2026 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed on February 21, 2023).
4.22	Form of the Registrant's 2030 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed on February 21, 2023).
4.23	Form of the Registrant's 2033 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed on February 21, 2023).
4.24	Form of the Registrant's 2053 Note (incorporated by reference to Exhibit 4.4 to the Registrant's Current Report on Form 8-K filed on February 21, 2023).
4.25	Form of the Registrant's 2029 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed June 2, 2023).
4.26	Form of the Registrant's 2031 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed June 2, 2023).
4.27	Form of the Registrant's 2033 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed June 2, 2023).
4.28	Form of the Registrant's 2053 Note (incorporated by reference to Exhibit 4.4 to the Registrant's Current Report on Form 8-K filed June 2, 2023).
4.29	Form of the Registrant's 2063 Note (incorporated by reference to Exhibit 4.5 to the Registrant's Current Report on Form 8-K filed June 2, 2023).
4.30	Form of the Registrant's 2029 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed May 9, 2024).
4.31	Form of the Registrant's 2031 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed May 9, 2024).
4.32	Form of the Registrant's 2034 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed May 9, 2024).
4.33	Form of the Registrant's 2044 Note (incorporated by reference to Exhibit 4.4 to the Registrant's Current Report on Form 8-K filed May 9, 2024).
4.34	Form of the Registrant's 2054 Note (incorporated by reference to Exhibit 4.5 to the Registrant's Current Report on Form 8-K filed May 9, 2024).
4.35	Form of the Series A Junior Subordinated Notes (incorporated by reference to Exhibit A of Exhibit 4.2 to the Registrant's Current Report on Form 8-K Filed December 10, 2024).
4.36	Form of the Series B Junior Subordinated Notes (incorporated by reference to Exhibit A of Exhibit 4.3 to the Registrant's Current Report on Form 8-K Filed December 10, 2024).
4.37	Form of the Registrant's 2032 Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed August 15, 2025).
4.38	Form of the Registrant's 2035 Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed August 15, 2025).
4.39	Form of the Registrant's 2055 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed August 15, 2025).
4.40	Form of the Registrant's 2065 Note (incorporated by reference to Exhibit 4.4 to the Registrant's Current Report on Form 8-K filed August 15, 2025).
4.41	Material terms of outstanding securities that are registered under Section 12 of the 1934 Act as required by Item 202(a)-(d) and (f) of Regulation S-K.
10	**Material Contracts**
10.1	Confidentiality Agreement, dated November 17, 2024, by and between the Registrant and Glenview Capital Management, LLC (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed November 18, 2024).

10.2	Five Year Credit Agreement, dated as of May 16, 2019, by and among the Registrant, the lenders party thereto and Bank of America N.A., as Administrative Agent (incorporated by reference to Exhibit 10.2 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.3	First Amendment to Five Year Credit Agreement dated as of May 16, 2022, to the Five Year Credit Agreement dated as of May 16, 2019, by and among the Registrant, the lenders party thereto and Bank of America, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.3 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2022).
10.4	Second Amendment to Five Year Credit Agreement dated as of March 23, 2023, to the Five Year Credit Agreement, dated as of May 16, 2019, as amended by the First Amendment to Five Year Credit Agreement, dated as of May 16, 2022, by and among the Registrant, the lenders party thereto and Bank of America N.A. as Administrative Agent (incorporated by reference to Exhibit 10.5 of Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ending March 31, 2023).
10.5	Third Amendment to Five Year Credit Agreement dated as of May 16, 2024, to the Five Year Credit Agreement dated as of May 16, 2019, as amended by the Second Amendment to Five Year Credit Agreement, dated as of March 23, 2023, as amended by the First Amendment to Five Year Credit Agreement, dated as of May 16, 2022,by and among the Registrant, the lenders party thereto and Bank of America, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2024).
10.6	Five Year Credit Agreement dated as of May 11, 2021, by and among the Registrant, the lenders party thereto, and Bank of America, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2021).
10.7	First Amendment to Five Year Credit Agreement dated as of May 16, 2022, to the Five Year Credit Agreement dated as of May 11, 2021, by and among the Registrant, the lenders party thereto and Bank of America, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.2 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2022).
10.8	Second Amendment to Five Year Credit Agreement dated as of March 23, 2023, to the Five Year Credit Agreement, dated as of May 11, 2021, as amended by the First Amendment to Five Year Credit Agreement, dated as of May 16, 2022, by and among the Registrant, the lenders party thereto and Bank of America N.A. as Administrative Agent (incorporated by reference to Exhibit 10.6 of Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ending March 31, 2023).
10.9	Third Amendment to Five Year Credit Agreement dated as of May 16, 2024, to the Five Year Credit Agreement dated as of May 11, 2021, as amended by the Second Amendment to Five Year Credit Agreement, dated as of March 23, 2023, as amended by the First Amendment to Five Year Credit Agreement, dated as of May 16, 2022, by and among the Registrant, the lenders party thereto and Bank of America, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2024).
10.10	Fourth Amendment to Five Year Credit Agreement dated as of May 16, 2025, to the Five Year Credit Agreement dated as of May 11, 2021, as amended by the Third Amendment to Five Year Credit Agreement, dated as of May 16, 2024, as amended by the Second Amendment to Five Year Credit Agreement, dated as of March 23, 2023, as amended by the First Amendment to Five Year Credit Agreement, dated as of May 16, 2022, by and among the Registrant, the lenders party thereto and Bank of America, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2025).
10.11	Five Year Credit Agreement dated as of May 16, 2022, by and among the Registrant, the lenders party thereto, and Bank of America, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2022).
10.12	First Amendment to Five Year Credit Agreement dated as of March 23, 2023, to the Five Year Credit Agreement, dated as of May 16, 2022, by and among the Registrant, the lenders party thereto and Bank of America N.A. as Administrative Agent (incorporated by reference to Exhibit 10.7 of Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ending March 31, 2023).
10.13	Second Amendment to Five Year Credit Agreement dated as of May 16, 2024, to the Five Year Credit Agreement dated as of May 16, 2022, as amended by the First Amendment to Five Year Credit Agreement, dated as of March 23, 2023, by and among the Registrant, the lenders party thereto and Bank of America, N.A., 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, 2024).
10.14*	Universal 409A Definition Document, as amended (incorporated by reference to Exhibit 10.28 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
10.15 *	The Registrant's Supplemental Retirement Plan I for Select Senior Management, as amended and restated as of December 31, 2008 (incorporated by reference to Exhibit 10.6 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2009).
10.16*	Form of Enterprise Non-Competition, Non-Disclosure and Developments Agreement between the Registrant and certain of the Registrant's executive officers (incorporated by reference to Exhibit 10.25 of the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013).

10.17*	The Registrant's Deferred Stock Compensation Plan, as amended and restated (incorporated by reference to Exhibit 10.11 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2019).
10.18*	The Registrant's 2007 Employee Stock Purchase Plan, as amended (incorporated by reference to Exhibit 99.2 to the Registrant's Registration Statement on Form S-8 filed May 19, 2020).
10.19*	Amendment to Registrant's 2007 Employee Stock Purchase Plan dated May 2, 2023 (incorporated by reference to Exhibit 10.1 of Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ending June 30, 2023).
10.20*	The Registrant's Amended and Restated Deferred Compensation Plan (incorporated by reference to Exhibit 10.10 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2021).
10.21*	The Registrant's Partnership Equity Program, as amended (incorporated by reference to Exhibit 10.25 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.22*	The Registrant's Performance-Based Restricted Stock Unit Plan, as amended (incorporated by reference to Exhibit 10.27 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016).
10.23*	The Registrant's 2017 Incentive Compensation Plan, as amended (incorporated by reference to Exhibit 99.1 to the Registrant's Registration Statement on Form S-8 filed May 23, 2024).
10.24*	Forms of award agreements to be used under the 2017 ICP, as amended (incorporated by reference to Exhibit 10.2 to the Registrant's Current Report on Form 8-K filed May 22, 2024).
10.25*	The Registrant's Executive Incentive Plan, as amended (incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017).
10.26*	The Registrant's Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017).
10.27*	Oak Street Health, Inc. Omnibus Incentive Plan (incorporated by reference to Exhibit 99.1 to the Registrant's Registration Statement on Form S-8 filed May 2, 2023).
10.28*	Oak Street Health, Inc. Omnibus Incentive 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, 2024).
10.29*	Signify Health, Inc. 2021 Long-Term Incentive Plan (incorporated by reference to Exhibit 99.1 to the Registrant's Registration Statement on Form S-8 filed March 29, 2023).
10.30*	Signify Health, Inc. 2021 Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 99.1 to the Registrant's Registration Statement on Form S-8 filed August 2, 2023).
10.31*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.29 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.32*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.39 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.33*	Form of Nonqualified Stock Option Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.55 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2021).
10.34*	Form of Nonqualified Stock Option Agreement between the Registrant and selected executives of the Registrant (incorporated by reference to Exhibit 10.3 of Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ending March 31, 2022).
10.35*	Form of Nonqualified Stock Option Agreement between the Registrant and selected executives of the Registrant (incorporated by reference to Exhibit 10.4 of Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ending March 31, 2022).
10.36*	Form of Premium Nonqualified Stock Option Agreement between the Registrant and selected executives of the Registrant (incorporated by reference to Exhibit 10.35 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2024).
10.37*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.30 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.38*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.40 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.39*	Form of Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant. (incorporated by reference to Exhibit 10.1 of Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ending March 31, 2022).
10.40*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.41*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.41 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).

10.42*	The Registrant's Performance-Based Restricted Stock Unit Program, as amended (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.43*	Form of Performance Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.2 of Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ending March 31, 2022).
10.44*	Form of Registrant's Performance Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.2 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2025).
10.45*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax) (incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.46*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax) (incorporated by reference to Exhibit 10.42 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2018).
10.47*	Form of Partnership Equity Program Participant Purchased Share, Company Matching RSUs and Company Matching Option Agreement (Post-Tax) (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013).
10.48*	Form of Partnership Equity Program Participant Purchased Share, Company Matching RSUs and Company Matching Option Agreement (Post-Tax) (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014).
10.49*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018).
10.50*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.5 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2019).
10.51*	Form of Performance Stock Unit Agreement (LTIP) - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018).
10.52*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended September 30, 2020).
10.53*	The Registrant's Management Incentive Plan (incorporated by reference to Exhibit 10.51 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2024).
10.54*	The Registrant's Amended and Restated Severance Plan for Non-Store Employees dated January 1, 2025 (incorporated by reference to Exhibit 10.52 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2024).
10.55*	The Registrant's Executive Health Program Summary and Program Document effective September 20, 2023 (incorporated by reference to Exhibit 10.47 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2023).
10.56*	Restrictive Covenant Agreement dated January 7, 2024 between the Registrant and Thomas F. Cowhey (incorporated by reference to Exhibit 10.53 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2023).
10.57*	Change in Control Agreement effective as of January 5, 2024 between the Registrant and Thomas F. Cowhey (incorporated by reference to Exhibit 10.54 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2023).
10.58*	Restrictive Covenant Agreement dated June 20, 2022 between the Registrant and Tilak Mandadi (incorporated by reference to Exhibit 10.1 of Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ending March 31, 2023).
10.59*	Change in Control Agreement effective as of August 11, 2022 between the Registrant and Tilak Mandadi (incorporated by reference to Exhibit 10.2 of Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ending March 31, 2023).
10.60*	Restrictive Covenant Agreement dated May 11, 2022 between the Registrant and Prem Shah (incorporated by reference to Exhibit 10.3 of Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ending March 31, 2023).
10.61*	Change in Control Agreement effective as of January 27, 2023 between the Registrant and Prem Shah (incorporated by reference to Exhibit 10.4 of Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ending March 31, 2023).
10.62*	Restrictive Covenant Agreement dated January 17, 2023 between the Registrant and Samrat Khichi (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2024).

10.63*	Change in Control Agreement effective as of February 20, 2023 between the Registrant and Samrat Khichi (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2024).
10.64*	Restrictive Covenant Agreement dated August 28, 2024 between the Registrant and Heidi B. Capozzi (incorporated by reference to Exhibit 10.3 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2025).
10.65*	Change in Control Agreement effective as of August 26, 2024 between the Registrant and Heidi B. Capozzi (incorporated by reference to Exhibit 10.4 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2025).
10.66*	Restrictive Covenant Agreement dated January 25, 2023 between the Registrant and J. David Joyner (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2025).
10.67*	Change in Control Agreement effective as of January 31, 2023 between the Registrant and J. David Joyner (incorporated by reference to Exhibit 10.2 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2025).
10.68*	Promotion Grant Award Agreement dated November 30, 2024 between the Registrant and J. David Joyner.
10.69*	Descriptions of certain arrangements not embodied in formal documents as described under the heading "Non-Employee Director Compensation" are incorporated herein by reference to the Proxy Statement (when filed).
19	**Insider trading policies and procedures**
19.1	Securities Trading Policy of CVS Health Corporation, as amended January 28, 2025 (incorporated by reference to Exhibit 19.1 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2024).
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.
97	**Policy Relating to Recovery of Erroneously Awarded Compensation**
97.1*	Registrant's Dodd-Frank Clawback Policy adopted September 21, 2023 (incorporated by reference to Exhibit 97.1 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2023).
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, 2025 formatted in Inline XBRL: (i) the Consolidated Statements of Operations, (ii) the Consolidated Statements of Comprehensive Income, (iii) the Consolidated Balance Sheets, (iv) the Consolidated Statements of Cash Flows, (v) the Consolidated Statements of Shareholders' Equity and (vi) the related Notes to Consolidated Financial Statements. The instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
104	
104	Cover Page Interactive Data File - The cover page from the Company's Annual Report on Form 10-K for the year ended December 31, 2025, formatted in Inline XBRL (included as Exhibit 101).

Item 16. Form 10-K Summary.

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

CVS HEALTH CORPORATION

Date: February 10, 2026

By: /s/ BRIAN O. NEWMAN

Brian O. Newman
Executive Vice President and Chief Financial Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title(s)	Date
/s/ FERNANDO AGUIRRE **Fernando Aguirre**	Director	February 10, 2026
/s/ JEFFREY R. BALSER, M.D., Ph.D. **Jeffrey R. Balser, M.D., Ph.D.**	Director	February 10, 2026
/s/ C. DAVID BROWN II **C. David Brown II**	Director	February 10, 2026
/s/ JAMES D. CLARK **James D. Clark**	Senior Vice President - Controller and Chief Accounting Officer (Principal Accounting Officer)	February 10, 2026
/s/ ALECIA A. DECOUDREAUX **Alecia A. DeCoudreaux**	Director	February 10, 2026
/s/ ROGER N. FARAH **Roger N. Farah**	Director	February 10, 2026
/s/ ANNE M. FINUCANE **Anne M. Finucane**	Director	February 10, 2026
/s/ J. DAVID JOYNER **J. David Joyner**	President, Chief Executive Officer (Principal Executive Officer), Chair of the Board and Director	February 10, 2026
/s/ J. SCOTT KIRBY **J. Scott Kirby**	Director	February 10, 2026
/s/ MICHAEL F. MAHONEY **Michael F. Mahoney**	Director	February 10, 2026
/s/ BRIAN O. NEWMAN **Brian O. Newman**	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 10, 2026
/s/ LESLIE V. NORWALK **Leslie V. Norwalk**	Director	February 10, 2026
/s/ LARRY M. ROBBINS **Larry M. Robbins**	Director	February 10, 2026
/s/ GUY P. SANSONE **Guy P. Sansone**	Director	February 10, 2026
/s/ DOUGLAS H. SHULMAN **Douglas H. Shulman**	Director	February 10, 2026

CVS Health
One CVS Drive
Woonsocket, RI 02895
401-765-1500
CVSHealth.com

Trees saved	Water saved	Energy saved	Greenhouse gases not produced	Hazardous air pollutants not produced
4 fully grown	**887 gallons**	**1.8 million BTUs**	**2,090 pounds CO2**	**0.138 pounds**

Environmental impact estimates were calculated using the Environmental Network Paper Calculator Version 4.0. For more information, visit **www.PaperCalculator.org**