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

FORM 10-K

☒ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the fiscal year ended December 31, 2012

OR

☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the transition period from to

Commission file number 001-01011

CVS CAREMARK CORPORATION

(Exact name of Registrant as specified in its charter)

Delaware	**050494040**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	**(Zip Code)**

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

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

Common Stock, par value $0.01 per share	**New York Stock Exchange**
Title of each class	**Name of each exchange on which registered**

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

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

Large accelerated filer ☒ Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company) Smaller reporting company ☐

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 $59,275,089,023 as of June 30, 2012, based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be the affiliates of the registrant.

As of February 8, 2013, the registrant had 1,231,194,296 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Filings made by companies with the Securities and Exchange Commission sometimes "incorporate information by reference." This means that the company is referring you to information that was previously filed or is to be filed with the SEC, and this information is considered to be part of the filing you are reading. The following materials are incorporated by reference into this Form 10-K:

- Portions of our Annual Report to Stockholders for the fiscal year ended December 31, 2012 is incorporated by reference in our response to Items 7, 8 and 9 of Part II.
- Information contained in our Proxy Statement for the 2013 Annual Meeting of Stockholders is incorporated by reference in our response to Items 10 through 14 of Part III.

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PART I

Item 1. Business

Overview

CVS Caremark Corporation ("CVS Caremark", the "Company", "we" or "us"), together with its subsidiaries, is the largest integrated pharmacy health care provider in the United States. We are uniquely positioned to deliver significant benefits to health plan sponsors through effective cost management solutions and innovative programs that engage plan members and promote healthier and more cost-effective behaviors. Our integrated pharmacy services model enhances our ability to offer plan members and consumers expanded choice, greater access and more personalized services to help them on their path to better health. We effectively manage pharmaceutical costs and improve health care outcomes through our pharmacy benefit management ("PBM"), mail order and specialty pharmacy division, CVS Caremark® Pharmacy Services ("Caremark"); our more than 7,400 CVS/pharmacy® retail stores; our retail-based health clinic subsidiary, MinuteClinic®; and our online retail pharmacy, CVS.com®.

We currently have three reportable segments: Pharmacy Services, Retail Pharmacy and Corporate.

Pharmacy Services Segment

The Pharmacy Services business provides a full range of PBM services, as described more fully below, to our clients consisting primarily of employers, insurance companies, unions, government employee groups, managed care organizations ("MCOs") and other sponsors of health benefit plans and individuals throughout the United States. In addition, through our SilverScript Insurance Company ("SilverScript") and Pennsylvania Life Insurance Company ("Pennsylvania Life") subsidiaries, we are a national provider of drug benefits to eligible beneficiaries under the Federal Government's Medicare Part D program. The Pharmacy Services Segment operates under the CVS Caremark® Pharmacy Services, Caremark®, CVS Caremark®, CarePlus CVS/pharmacy®, RxAmerica® and Accordant® names. As of December 31, 2012, the Pharmacy Services Segment operated 31 retail specialty pharmacy stores, 12 specialty mail order pharmacies and five mail service pharmacies located in 22 states, Puerto Rico and the District of Columbia.

Pharmacy Services Business Strategy - Our business strategy centers on providing innovative pharmaceutical solutions and quality client service in order to enhance clinical outcomes for our clients' health benefit plan members while assisting our clients and their plan members in better managing overall health care costs. Our goal is to produce superior results for our clients and their plan members by leveraging our expertise in core PBM services, including: plan design and administration, formulary management, discounted drug purchase arrangements, Medicare Part D services, mail order and specialty pharmacy services, retail pharmacy network management services, prescription management systems, clinical services and disease management services.

In addition, as a fully integrated pharmacy services company, we are able to offer our clients and their plan members a variety of programs and plan designs that benefit from our integrated information systems and the ability of our more than 26,000 pharmacists, nurse practitioners and physician assistants to interact personally with the many plan members who shop our stores every day. Through our multiple member touch points (retail stores, mail order and specialty pharmacies, retail clinics, call centers and proprietary websites), we seek to engage plan members in behaviors that lower cost and improve health care outcomes. Examples of these programs and services include: Maintenance Choice®, a program where eligible client plan members can elect to fill their maintenance prescriptions at our retail pharmacy stores for the same price as mail order; Pharmacy Advisor®, a program that uses our Consumer Engagement Engine™ technology to facilitate face-to-face and telephone counseling by our pharmacists to help participating plan members with certain chronic diseases, such as diabetes and cardiovascular conditions, to identify gaps in care, adhere to their prescribed medications and manage their health conditions; compliance and persistency programs designed to ensure that patients take their medications in the proper manner; enhanced disease management programs that are targeted at managing chronic disease states; and an ExtraCare® Health Card program which offers discounts to eligible plan members on certain over-the-counter health care products sold in our CVS/pharmacy stores. In addition, we are working with our clients to (i) decrease unnecessary and expensive emergency room visits by encouraging plan members to use MinuteClinic® locations for everyday common ailments and (ii) create pilot programs that offer convenient and unique services available at MinuteClinic, such as injection training for specialty pharmacy services.

PBM Services - Our PBM services are described more fully below.

Plan Design and Administration - Our clients sponsor pharmacy benefit plans that facilitate the ability of eligible members in these plans to receive prescribed medications. We assist our clients in designing pharmacy benefit plans that minimize the costs to the client while prioritizing the welfare and safety of the clients' members. We also administer these benefit plans for our clients and assist them in monitoring the effectiveness of these plans through frequent, informal communications as well as through a formal annual client review.

We make recommendations to our clients encouraging them to design benefit plans promoting the use of the lowest cost, most clinically appropriate drug. We believe that we help our clients control costs by recommending plan designs that encourage the use of generic equivalents of brand name drugs when such equivalents are available. Our clients also have the option, through plan design, to further lower their pharmacy benefit plan costs by setting different member payment levels for different products on their drug lists.

Formulary Management - We utilize an independent panel of doctors, pharmacists and other medical experts, referred to as our Pharmacy and Therapeutics Committee, to select drugs that meet the highest standards of safety and efficacy for inclusion on our drug lists. Our drug lists provide recommended products in numerous drug classes to ensure member access to clinically appropriate alternatives under the client's pharmacy benefit plan. To improve clinical outcomes for members and clients, we conduct ongoing, independent reviews of all drugs, including, but not limited to, those appearing on the drug lists and generic equivalent products, as well as our clinical programs. Many of our clients choose to adopt our drug lists as part of their plan design.

Discounted Drug Purchase Arrangements - We negotiate with pharmaceutical companies to obtain discounted acquisition costs for many of the products on our drug lists, and these negotiated discounts enable us to offer reduced costs to clients that choose to adopt our drug lists. The discounted drug purchase arrangements we negotiate typically provide for volume discounts and/or the payment by the pharmaceutical companies of retroactive discounts, or rebates, from established list prices. For certain products that are purchased by our pharmacies, we receive discounts at the time of purchase and/or discounts for prompt payment of invoices. We also receive various purchase discounts under our wholesale contracts, which may include retroactive discounts, or rebates, if we exceed contractually-defined purchase volumes. We record these discounts, regardless of their form, as a reduction of our cost of revenues.

Medicare Part D Services - We participate in the administration of the drug benefit added to the Medicare program under Part D of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") ("Medicare Part D") through the provision of PBM services to our health plan clients and other clients that have qualified as Medicare Part D prescription drug plans ("PDP"). We also participate (i) by offering Medicare Part D pharmacy benefits through our subsidiaries, SilverScript and Pennsylvania Life, which have been approved as PDPs by the Centers for Medicare and Medicaid Services ("CMS"), and (ii) by assisting employer, union and other health plan clients that qualify for the retiree drug subsidy available under Medicare Part D by collecting and submitting eligibility and/or drug cost data to CMS in order for them to obtain the subsidy.

Mail Order Pharmacy - As of December 31, 2012, we operated five large, automated mail service pharmacies in the United States. Plan members or their prescribers submit prescriptions or refill requests, primarily for maintenance medications, to these pharmacies via mail, telephone, fax, e-prescribing or the Internet. We also operate a network of smaller mail service specialty pharmacies described below. Our staff pharmacists review mail service prescriptions and refill requests with the assistance of our prescription management systems. This review may involve communications with the prescriber and, with the prescriber's approval, can result in generic substitution, therapeutic interchange or other actions designed to reduce cost and improve quality of treatment.

Specialty Pharmacy - Our specialty pharmacies support individuals that require complex and expensive drug therapies. As of December 31, 2012, our specialty pharmacies were comprised of 12 specialty mail order pharmacies located throughout the United States that are used for delivery of advanced medications to individuals with chronic or genetic diseases and disorders. Substantially all of these pharmacies have been accredited by the Joint Commission, which is an independent, not-for-profit organization that accredits and certifies more than 19,000 health care organizations and programs in the United States. As of December 31, 2012, the Company operated a network of 31 retail specialty pharmacy stores, which operate under the CarePlus CVS/pharmacy® name. These stores average 2,000 square feet in size and sell prescription drugs and a limited assortment of front store items such as alternative medications, homeopathic remedies and vitamins.

Retail Pharmacy Network Management - We maintain a national network of approximately 67,000 retail pharmacies, including CVS/pharmacy stores. When a customer fills a prescription in a retail pharmacy, the pharmacy sends prescription data electronically to us from the point-of-sale. This data interfaces with our proprietary prescription management systems, which verify relevant plan member data and eligibility, while also performing a drug utilization review to evaluate clinical appropriateness and safety and confirming that the pharmacy will receive payment for the prescription.

Prescription Management Systems - We dispense prescription drugs both directly, through one of our mail service or specialty pharmacies, or through a network of retail pharmacies. All prescriptions, whether they are filled through one of our mail service pharmacies or through a pharmacy in our retail network, are analyzed, processed and documented by our proprietary prescription management systems. These systems assist staff and network pharmacists in processing prescriptions by automating review of various items, including, but not limited to, plan eligibility, early refills, duplicate dispensing, appropriateness of dosage, drug interactions or allergies, over-utilization and potential fraud.

Clinical Services - We offer multiple clinical programs and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner. Our programs are primarily designed to promote safety, and to target inappropriate utilization and non-adherence to medication, each of which may result in adverse medical events that negatively impact members' health and the client's pharmacy and medical spend. In this regard, we offer various utilization management, medication management, quality assurance, adherence and counseling programs to complement the client's plan design and clinical strategies.

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

Pharmacy Services Information Systems - We currently operate multiple information systems platforms to support our Pharmacy Services Segment. These information systems incorporate architecture that centralizes the data generated from filling mail service prescriptions, adjudicating retail pharmacy claims and fulfilling other services we provide to PBM clients. As part of our streamlining initiative, we are consolidating our adjudication platforms to one destination platform with enhanced capabilities.

Pharmacy Services Clients - Our clients are primarily sponsors of health benefit plans (employers, insurance companies, unions, government employee groups andMCOs) and individuals located throughout the United States. We provide pharmaceuticals to eligible members in benefit plans maintained by our clients and utilize our information systems, among other things, to perform safety checks, drug interaction screening and generic substitution. We generate substantially all of our Pharmacy Services Segment net revenue from dispensing prescription drugs to eligible members in benefit plans maintained by our clients. No single PBM client accounted for 10% or more of our total consolidated revenues in 2012. Our client agreements are subject to renegotiation of terms. See "Risk Factors – Efforts to reduce reimbursement levels and alter health care financing practices" and "Risk Factors – Risks of declining gross margins in the PBM industry." During the year ended December 31, 2012, our PBM filled or managed approximately 881 million prescriptions.

Pharmacy Services Seasonality - The majority of our Pharmacy Services Segment revenues are not seasonal in nature.

Pharmacy Services Competition - We believe the primary competitive factors in the industry include: (i) the ability to negotiate favorable discounts from drug manufacturers; (ii) the ability to negotiate favorable discounts from, and access to, retail pharmacy networks; (iii) responsiveness to clients' needs; (iv) the ability to identify and apply effective cost management programs utilizing clinical strategies; (v) the ability to develop and utilize preferred drug lists; (vi) the ability to market PBM products and services; (vii) the commitment to provide flexible, clinically-oriented services to clients; and (viii) the quality, scope and costs of products and services offered to clients and their members. The Pharmacy Services Segment has a significant number of competitors offering PBM services (e.g., Express Scripts, Catamaran, OptumRx and Prime Therapeutics) including large, national PBM companies, PBMs owned by large national health plans and smaller standalone PBMs.

Retail Pharmacy Segment

As of December 31, 2012, the Retail Pharmacy Segment included 7,458 retail drugstores, of which 7,402 operated a pharmacy, our online retail pharmacy website, CVS.com, 19 onsite pharmacy stores and our retail health care clinics. The retail drugstores are located in 42 states, Puerto Rico and the District of Columbia operating primarily under the CVS/pharmacy® name. We currently operate in 92 of the top 100 U.S. drugstore markets and hold the number one or number two market share in 74 of these markets. CVS/pharmacy stores sell prescription drugs and a wide assortment of over-the-counter and personal care products, beauty and cosmetic products, and general merchandise, which we refer to as "front store" products. Existing retail stores range in size from approximately 5,000 to 30,000 square feet, although most new stores range in size from approximately 8,000 to 15,000 square feet and typically include a drive-thru pharmacy. During 2012, we filled approximately 718 million retail prescriptions, or approximately 21% of the U.S. retail pharmacy market.

As of December 31, 2012, we operated 640 retail health care clinics in 26 states and the District of Columbia under the MinuteClinic® name, 633 of which were located within CVS/pharmacy stores.

Retail Pharmacy Business Strategy - Our integrated pharmacy services model has enhanced the ability of our retail pharmacy stores to expand customer access to care while helping to lower overall health care costs and improve health outcomes. In that regard, the role of our retail pharmacist is shifting from primarily dispensing prescriptions to also providing services, including flu vaccinations as well as face-to-face patient counseling with respect to adherence to drug therapies, closing gaps in care and more cost effective drug therapies. In addition, we seek to be the easiest pharmacy retailer for customers to use. We believe that ease of use means convenience for the time-starved customer. As such, our strategy is to have conveniently-located stores, many of which are open extended-hours or 24-hours per day, and to offer drive-through pharmacy services where practicable. We also provide a broad assortment of quality merchandise at competitive prices using a retail format that emphasizes service, innovation and convenience (easy-to-access, clean, well-lit and well stocked). One of the keys to our strategy is technology, which allows us to focus on constantly improving service and exploring ways to provide more personalized product offerings and services. We believe that continuing to be the first to market with new and unique products and services, using innovative marketing and adjusting our mix of merchandise to match our customers' needs and preferences is very important to our ability to continue to improve customer satisfaction.

Retail Pharmacy Products and Services - A typical CVS/pharmacy store sells prescription drugs and a wide assortment of high-quality, nationally advertised brand name and private label merchandise. Front store categories include over-the-counter drugs, beauty products and cosmetics, photo finishing services, seasonal merchandise, greeting cards and convenience foods. We purchase our merchandise from numerous manufacturers and distributors. We believe that competitive sources are readily available for substantially all of the products we carry and the loss of any one supplier would not have a material effect on the business.

Consolidated net revenues by major product group are as follows:

	Percentage of Net Revenues[1]		
	2012	2011	2010
Prescription drugs	68.8%	68.3%	68.0%
Over-the-counter and personal care	10.8	10.9	10.9
Beauty/cosmetics	5.0	5.2	5.1
General merchandise and other	15.4	15.6	16.0
	100.0%	100.0%	100.0%

(1) Percentages are estimates based on store point-of-sale data.

Pharmacy - Pharmacy revenues represented more than two-thirds of Retail Pharmacy revenues in each of 2012, 2011 and 2010. We believe that our pharmacy operations will continue to represent a critical part of our business due to favorable industry trends (e.g., an aging American population consuming a greater number of prescription drugs, pharmaceuticals being used more often as the first line of defense for managing illness, and the impact of health care reform), the proliferation of new pharmaceutical products, Medicare Part D and our ongoing program of purchasing customer lists from independent pharmacies. We believe our pharmacy business benefits from our investment in both people and technology. Given the nature of prescriptions, people want their prescriptions filled accurately and ready when promised, by professional pharmacists using the latest tools and technology. Consumers need medication management programs and better information to help them get the most out of their health care dollars. To assist our customers with these needs, we have introduced integrated pharmacy health care services that provide an earlier, easier and more effective approach to engaging them in behaviors that can help lower costs, improve health, and save lives. Examples include: our Patient Care Initiative, an enhanced medication adherence program; our Customer Savings Initiative, which educates customers about cost savings opportunities; Maintenance Choice; Pharmacy Advisor, our program that uses our Consumer Engagement Engine technology to facilitate pharmacist counseling, both face-to-face and over the telephone, to help participating plan members with certain chronic diseases, such as diabetes and cardiovascular conditions, to identify gaps in care, adhere to their prescribed medications and manage their health conditions; and the ExtraCare Health Card program. Further evidencing our belief in the importance of pharmacy service is our continuing investment in technology, such as our Drug Utilization Review system that checks for harmful interactions between prescription drugs, over-the-counter products, vitamins and herbal remedies; our pharmacy fulfillment system, Rx Connect; our touch-tone telephone reorder system, Rapid Refill®; and our online business, CVS.com®.

Front Store - Front store revenues benefited from our strategy to be the first to market with new and unique products and services, using innovative marketing and adjusting our mix of merchandise to match our customers' needs and preferences. A key component of our front store strategy is our ExtraCare® card program, which is helping us continue to build our loyal customer base. The ExtraCare program is one of the largest and most successful retail loyalty programs in the United States. In addition, the ExtraCare program allows us to balance our marketing efforts so we can reward our best customers by providing them automatic sale prices, customized coupons, ExtraBucks® rewards and other benefits. Another component of our front store strategy is our unique product offerings, which include a full range of high-quality CVS/pharmacy® and proprietary brand products that are only available through CVS/pharmacy stores. We currently carry over 4,600 CVS/pharmacy and proprietary brand products, which accounted for approximately 18% of our front store revenues during 2012. Furthermore, we are tailoring certain groups of stores, such as our urban cluster stores, to better meet the needs of our customers.

MinuteClinic - As of December 31, 2012, we operated 640 MinuteClinic® locations in 26 states and the District of Columbia; of which 633 were located in CVS/pharmacy stores. MinuteClinics are staffed by nurse practitioners and physician assistants who utilize nationally recognized protocols to diagnose and treat minor health conditions, perform health screenings, monitor chronic conditions and deliver vaccinations. Many locations have also begun treating a variety of chronic conditions. Insurers value MinuteClinic because it provides convenient, high-quality, cost-effective care, in many cases offering an attractive alternative to the far more expensive emergency room. As a result, visits paid for by employers, health insurers or other third parties accounted for approximately 85% of MinuteClinic's total revenues in 2012. We anticipate opening up approximately 150 new clinics in CVS/pharmacy stores during 2013. MinuteClinic is collaborating with our Pharmacy Services Segment to help meet the needs of CVS Caremark's client plan members by offering programs that can improve member health and lower costs. MinuteClinic is now affiliated with 22 major health systems.

Onsite Pharmacies - We also operate a limited number of small pharmacies located at client sites under the CarePlus CVS/pharmacy® or CVS/pharmacy® name, which provide certain health plan members and customers with a convenient alternative for filling their prescriptions.

Retail Pharmacy Store Development - The addition of new stores has played, and will continue to play, a major role in our continued growth and success. Our store development program focuses on three areas: entering new markets, adding stores within existing markets and relocating stores to more convenient, freestanding sites. During 2012, we opened 150 new retail pharmacy stores, relocated 90 stores and closed 30 stores. During the last five years, we opened more than 1,300 new and relocated stores, and acquired approximately 500 stores. During 2013, we expect square footage growth of between 2% to 3%. We believe that continuing to grow our store base and locating stores in desirable geographic markets are essential components to compete effectively in the current managed care environment. As a result, we believe that our store development program is an integral part of our ability to maintain our leadership position in the retail drugstore industry.

Retail Pharmacy Information Systems - We have continued to invest in information systems to enable us to deliver exceptional customer service, enhance Safety and Quality, and expand our Patient Care Services while lowering operating costs. In 2012, we completed the rollout of WeCARE Workflow to all Retail Pharmacy locations. WeCARE Workflow is an integrated suite of enhancements to our RxConnect fulfillment system, Pharmacy POS terminals and phone system to support our Pharmacy Colleagues and Customers by seamlessly integrating and prioritizing prescription fulfillment, prescriber contact management, customer service actions and Patient Care interventions into a cohesive workflow. In the near term, this solution delivers improved efficiency and enhances the customer experience. Longer term, the solution provides a framework to accommodate the evolution of Pharmacy Practice and the expansion of our clinical programs. Our Consumer Engagement Engine technology and proprietary clinical algorithms enable us to identify opportunities for our Pharmacists to deliver face-to-face counseling regarding patient health and safety matters, including adherence issues, gaps in care and management of certain chronic health conditions. Our Digital Strategy empowers the consumer to navigate their pharmacy experience and manage their condition through our on-line and mobile tools that offer utility and convenience. In 2012, CVS.com gained a new look and added new tools such as, access to world-class drug information and personalization of Pharmacy services. We experienced strong adoption of our Digital solutions with our mobile app receiving critical acclaim for ease of use and our text message program experiencing unprecedented growth.

Retail Pharmacy Customers - Managed care organizations, government-funded health care programs (including state Medicaid plans and Medicare Part D drug plans), commercial employers and other third party plans accounted for 97.5% of our 2012 pharmacy revenues. The loss of any one payor should not have a material effect on our business. No single retail payor accounts for 10% or more of our total consolidated revenues. However, the success of our retail drugstore business is dependent upon our ability to establish and maintain contractual relationships with PBMs and other payors on acceptable terms. During 2012, Express Scripts completed a merger with Medco Health Solutions, thereby creating the largest PBM in the nation. In 2012, Express Scripts accounted for approximately 18% of our Retail Pharmacy Segment revenues. Our contracts with commercial payors and government-funded programs are subject to renegotiation of reimbursement rates. See "Government Regulation – Reimbursement" and Item 1A., "Risk Factors – *Efforts to reduce reimbursement levels and alter health care financing practices*."

Retail Pharmacy Seasonality - The majority of our revenues, particularly pharmacy revenues, are generally not seasonal in nature. However, front store revenues tend to be higher during the December holiday season. For additional information, we refer you to the Note "Quarterly Financial Information" in our Annual Report to Stockholders for the year ended December 31, 2012, which section is incorporated by reference herein.

Retail Pharmacy Competition - The retail drugstore business is highly competitive. We believe that we compete principally on the basis of: (i) store location and convenience, (ii) customer service and satisfaction, (iii) product selection and variety and (iv) price. In the markets we serve, we compete with other drugstore chains, supermarkets, discount retailers, independent pharmacies, membership clubs, Internet companies, and retail health clinics, as well as other mail order pharmacies and PBMs.

Corporate Segment

Our Corporate Segment provides management and administrative services to support the overall operations of the Company. The Corporate Segment consists of certain aspects of our executive management, corporate relations, legal, compliance, human resources, corporate information technology and finance departments.

Working Capital Practices

We fund the growth of our business through a combination of cash flow from operations, commercial paper, proceeds from sales-lease-back transactions, and long-term borrowings. For additional information on our working capital practices, we refer you to the caption "Liquidity and Capital Resources" in our Annual Report to Stockholders for the year ended December 31, 2012, which section is incorporated by reference herein. The majority of our non-pharmacy revenues are paid in cash, debit or credit cards, while managed care and other third party insurance programs, which typically settle in less than 30 days, represented approximately 99.1% of our consolidated pharmacy revenues, including both Retail Pharmacy and Pharmacy Services combined, in 2012. The remainder of consolidated pharmacy revenues are paid in cash, debit or credit cards. Our customer returns are not significant.

Associate Development

As of December 31, 2012, we employed approximately 203,000 associates, which included more than 26,000 pharmacists, nurse practitioners and physician assistants. In addition, approximately 77,000 associates were part-time employees who work less than 30 hours per week. To deliver the highest levels of service to our customers, we devote considerable time and attention to our people and service standards. We emphasize attracting and training knowledgeable, friendly and helpful associates to work in our organization.

Intellectual Property

We have registered and/or applied to register a variety of our trademarks and service marks used throughout our business, as well as domain names, and rely on a combination of copyright, patent, trademark and trade secret laws, in addition to contractual restrictions, to establish and protect our proprietary rights. We regard our intellectual property as having significant value in our Pharmacy Services and Retail Pharmacy segments. We are not aware of any facts that could materially impact our continuing use of any of our intellectual property.

Government Regulation

Overview - Our business is subject to federal and state laws and regulations that govern the purchase, sale and distribution of prescription drugs and related services, including administration and management of prescription drug benefits. Many of our PBM clients, including insurers and MCO, are themselves subject to extensive regulations that affect the design and implementation of prescription drug benefit plans that they sponsor. The application of these complex legal and regulatory requirements to the detailed operation of our business creates areas of uncertainty. There are numerous proposed health care laws and regulations at the federal and state levels, some of which could adversely affect our business if they are enacted. We are unable to predict what federal or state legislation or regulatory initiatives may be enacted in the future relating to our business or the health care industry in general, or what effect any such legislation or regulations might have on our business. Any failure or alleged failure to comply with applicable laws and regulations, or any adverse applications of, or changes in, the laws and regulations affecting our business, could have a material adverse effect on our operating results and/or financial condition.

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 (or the arranging for or recommending of the purchase, lease or order) of items or services for which payment may be made under Medicare, Medicaid or certain other federal health care programs. A number of states have similar laws, some of which are not limited to services paid for with government funds. State laws and exceptions or safe harbors vary and have been infrequently interpreted by courts or regulatory agencies. Sanctions for violating these federal and state anti-remuneration laws may include imprisonment, criminal and civil fines, and exclusion from participation in Medicare, Medicaid and other government-sponsored health care programs. The federal anti-remuneration law has been interpreted broadly by some courts, the Office of Inspector General (the "OIG") within the United States Department of Health and Human Services ("HHS") and administrative bodies. A broad interpretation of the federal anti-remuneration law is supported by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, "ACA"), which codified a reduced standard of "knowingly and willfully" by stating that this standard does not require that a person have actual knowledge of the federal anti-remuneration law or specific intent to violate this law. ACA also provides that a violation of the federal anti-remuneration law constitutes a false or fraudulent act under the Federal False Claims Act ("FCA"). Because of the federal statute's broad scope, HHS established certain safe harbor regulations that specify various practices that are protected from criminal or civil liability. Safe harbors exist for certain discounts offered to purchasers, certain personal services arrangements, certain payments made by vendors to group purchasing organizations, in certain cases the provision of electronic prescribing technology to physicians, and certain other transactions and relationships. A practice that does not fall within a safe harbor is not necessarily unlawful but may be subject to challenge by HHS. In addition, as part of ACA, additional statutory exceptions have been created to permit the provision of certain incentives to federal health care program beneficiaries, including retailer coupons, rebates or other rewards and incentives offered to promote access to care. Also, waivers have been granted by the OIG and CMS to allow Affordable Care Organization ("ACO") providers to give certain free items and services to beneficiaries that encourage adherence to clinical goals, such as a drug regimen, as long as such items or services do not encourage the beneficiary to seek care from an ACO provider. See Item 3, "Legal Proceedings" for further information.

Antitrust and Unfair Competition - The Federal Trade Commission ("FTC") has authority under Section 5 of the Federal Trade Commission Act ("FTCA") to investigate and prosecute practices that are "unfair trade practices" or "unfair methods of competition." Relief under the FTCA can encompass equitable relief and consumer redress. In addition, numerous lawsuits have been filed throughout the United States against pharmaceutical manufacturers, retail pharmacies and/or PBMs under various state and federal antitrust and unfair competition laws challenging, among other things: (i) brand drug pricing practices of pharmaceutical manufacturers, (ii) the maintenance of retail pharmacy networks by PBMs, and (iii) various other business practices of PBMs and retail pharmacies. To the extent that we appear to have actual or potential market power in a relevant market, our business arrangements and practices may be subject to heightened scrutiny from an anti-competitive perspective and possible challenge by state or federal regulators or private parties. See Item 3, "Legal Proceedings" for further information.

Compliance Programs - ACA requires that health care providers enrolled in Medicare and Medicaid must establish and maintain compliance programs that satisfy core requirements to be established by the Secretary of HHS in consultation with the OIG. The Secretary of HHS has not yet published information concerning these compliance programs or the timeframe for implementation. In addition, certain state government health care programs have compliance program requirements, and we are subject to various government agreements described under "Government Agreements and Mandates" below that also contain requirements relating to the maintenance of compliance programs.

Consumer Protection Laws - The federal government and most states have consumer protection laws that have been the basis for investigations, lawsuits and multi-state settlements relating to, among other matters, the marketing of loyalty programs and health care services, and financial incentives provided by drug manufacturers to pharmacies in connection with therapeutic interchange programs. In addition, the FTCA bars unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce. The Federal Postal Service Act generally prohibits the mailing of, and billing for, unordered merchandise. The FTC's Telemarketing Sales Rule also imposes extensive requirements and restrictions in connection with telemarketing of plans or programs that encourage the purchase of goods or services by consumers (See the "Telemarketing and Other Outbound Contacts" section below for further disclosures.).

Contract Audits - We are subject to audits of many of our contracts, including our PBM client contracts, our PBM rebate contracts, our pharmacy provider agreements and our contracts relating to Medicare Part D. Audits are typically conducted pursuant to certain provisions in our PBM contracts and provider agreements that grant audit rights and set forth applicable audit procedures. Because some of our contracts are with state or federal governments or with entities contracted with state or federal agencies, audits of these agreements are often regulated by the federal or state agencies responsible for administering federal or state benefits programs, including those which operate Medicaid fee for service plans, Managed Medicaid plans, Medicare Part D plans or Medicare Advantage organizations. The audits generally focus on, among other things, compliance with the applicable terms of our contracts and applicable legal requirements.

Disease Management Services Regulation - We provide disease management programs to PBM plan members for rare medical conditions and arrange for them to receive disease management programs for common medical conditions. Nurses, pharmacists and other clinicians, as needed, develop and implement these programs. State laws regulate the practice of medicine, the practice of pharmacy and the practice of nursing, and clinicians engaged in a professional practice must satisfy applicable state licensing requirements.

Electronic Prescribing - The federal government has implemented different programs to promote electronic prescribing, including the eRx Incentive Program established under the Medicare Improvements for Patients and Providers Act of 2008, which provides a combination of incentive payments and payment adjustments through 2014 to eligible professionals who are successful electronic prescribers. While this program sunsets after 2014, the American Recovery and Reinvestment Act of 2009 ("ARRA") established an incentive program for eligible professionals and hospitals participating in the Medicare or Medicaid program that adopt and meaningfully use certified electronic health records ("EHR") technology beginning in 2011. ARRA also provides for downward payment adjustments beginning in 2015 for eligible professionals in the Medicare program that fail to adopt and meaningfully use certified EHR technology such as electronic prescribing. A final rule implementing the Stage 1 criteria that eligible professionals must meet in order to qualify for Medicare and/or Medicaid EHR incentive payments was issued in July 2010 and requires that at least 40% of permissible prescriptions be sent electronically in order to qualify for the incentive payments. The final rule specifying the Stage 2 criteria was issued in September 2012 which, among other things, requires that more than 50 percent of all permissible prescriptions written by an eligible professional be queried for a drug formulary and transmitted electronically using a certified EHR technology. In March 2010, the U.S. Drug Enforcement Administration ("DEA") issued an interim final rule allowing electronic prescribing of controlled substances beginning June 1, 2010. These changes, together with the requirement for Medicare Part D plans to support electronic prescribing, should result in a growing number of prescribers adopting electronic prescribing.

Environmental Regulation - Our business is subject to various federal, state and local laws, regulations and other requirements pertaining to protection of the environment and public health, including, for example, regulations governing the management of waste materials and waste waters. Governmental agencies on the federal, state and local levels have, in recent years, increasingly focused on the retail sector's compliance with such laws and regulations, and have at times pursued enforcement activities. There is also an increased interest by regulators in better managing photo processing as well as pharmaceutical and other wastes. Our retail pharmacies have been subject to various state environmental agency enforcement actions, and we periodically receive information requests and notices of potential noncompliance with environmental laws and regulations from governmental agencies.

ERISA Regulation - The Employee Retirement Income Security Act of 1974, as amended ("ERISA"), provides for comprehensive federal regulation of certain employee pension and benefit plans, including private employer and union sponsored health plans and certain other plans that contract with us to provide PBM services. In general, we assist plan sponsors in the administration of the prescription drug portion of their health benefit plans, in accordance with the plan designs adopted by the plan sponsors. We do not believe that the conduct of our business subjects us to the fiduciary obligations of ERISA, except when we have specifically contracted with a plan sponsor to accept limited fiduciary responsibility, such as for the adjudication of initial prescription drug benefit claims and/or the appeals of denied claims under a plan. We and other PBMs have been named in lawsuits alleging that we act as a fiduciary, as such term is defined by ERISA, with respect to health benefit plans and that we have breached certain fiduciary obligations under ERISA.

ERISA fiduciaries may be held personally liable for entering into service contracts or arrangements, like PBM contracts, on behalf of ERISA plans if the terms of the contract are not reasonable or if the service provider receives more than reasonable compensation for the services provided. In such cases, the service provider may also be required to disgorge any unreasonable compensation received and may be subject to civil penalties imposed by the U.S. Department of Labor ("DOL").

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 similar, but not identical, to the health care anti-remuneration statutes discussed above, although ERISA lacks the statutory and regulatory "safe harbor" exceptions incorporated into the health care statutes. Similar to these health care statutes, the corresponding provisions of ERISA are broadly written and their application to specific business practices is often uncertain.

Most pension and welfare plans subject to ERISA are required to report to the DOL compensation paid to service providers. In addition, the DOL announced a project in 2009 to promulgate regulations under ERISA that could require service providers, including PBMs, to provide detailed disclosure regarding all direct and indirect compensation to be received in connection with the services provided as well as potential conflicts of interest. The DOL issued supplemental "frequently asked questions" in 2010 that specifically addressed PBM disclosure of certain compensation, including: (i) fees for services, such as dispensing fees and administrative fees, which are reportable as direct compensation, and (ii) discounts and rebates received by PBMs from pharmaceutical companies, which pending further guidance from the DOL generally do not need to be treated as reportable indirect compensation. In February 2012, the DOL issued final regulations that impose numerous disclosure requirements on service providers and provide that contracts or arrangements with service providers will not be considered "reasonable" under ERISA unless the required disclosures are made. The required disclosures must be timely made to plan fiduciaries and must include, among other things, a description of the services provided, a description of direct and indirect compensation for the services and a description of the compensation expected to be received upon termination of the contract or arrangement.

State laws discussed in this Government Regulation section that may be applicable to us or to plan sponsors that are our customers may be preempted in whole or in part by ERISA. However, the scope of ERISA preemption is uncertain and is subject to conflicting court rulings.

False Claims and Fraudulent Billing Statutes - A range of federal civil and criminal laws target false claims and fraudulent billing activities. One of the most significant of these laws is the FCA, which prohibits the submission of a false claim or the making of a false record or statement in order to secure reimbursement from, or limit reimbursement to, a government-sponsored program. The Fraud Enforcement and Recovery Act of 2009 ("FERA") implemented substantial changes to the FCA which expand the scope of FCA liability, provide for new investigative tools and make it easier for *qui tam* relators (often referred to as "whistleblowers") to bring and maintain FCA suits on behalf of the government. ACA further eased the burden for whistleblowers to bring and maintain FCA suits by modifying the "public disclosure" and "original source" provisions of the FCA. Some states have passed substantially similar acts. In recent years, federal and state governments have launched several initiatives aimed at uncovering practices that violate false claims or fraudulent billing laws. FERA also expanded the FCA to cover improperly avoiding an obligation to pay money to the government, and ACA clarified that the retention of overpayments beyond the repayment deadline is a violation of the FCA. In addition, ACA provides that a violation of the federal anti-remuneration law constitutes a false or fraudulent act under the FCA and expands the jurisdiction of the FCA to the health insurance exchanges to be created under ACA. ACA also provides for the imposition of civil monetary penalties for knowingly making or causing to be made any false or fraudulent record or statement material to a false or fraudulent claim for payment under a government-sponsored program, for knowingly failing to report and return an overpayment, and for false statements in provider enrollment applications. The Federal Deficit Reduction Act of 2005 ("DRA"), for example, requires certain entities that receive or make annual Medicaid payments over a certain amount to provide their employees and certain contractors and agents with certain information regarding the federal and state false claims acts, whistleblower protections, and the entity's processes for detecting and preventing fraud, waste and abuse. Claims under these laws may be brought either by the government or by private individuals on behalf of the government through a *qui tam* or "whistleblower" action, as discussed in more detail elsewhere in this Government Regulation section. In recent years, federal and state government authorities have launched several initiatives aimed at uncovering practices that violate false claims or fraudulent billing laws, and they have conducted numerous investigations of pharmaceutical manufacturers, PBMs, pharmacies and health care providers with respect to false claims, fraudulent billing and related matters. See Item 3, "Legal Proceedings" for further information.

FDA Regulation - The United States Food and Drug Administration ("FDA") generally has authority to regulate drugs, drug classifications and drug promotional information and materials that are disseminated by a drug manufacturer or by other persons on behalf of a drug manufacturer. The FDA also has the regulatory authority over many of the products sold through retail pharmacies, including certain food items, cosmetics, dietary supplements and over-the-counter ("OTC") medications. We previously operated a FDA-regulated repackaging facility where we repackaged certain drugs into the most common prescription quantities dispensed from our mail service pharmacies, but we closed this repackaging facility in April 2010. The FDA also may inspect facilities in connection with procedures implemented to effect recalls of prescription drugs or other FDA-regulated products, as well as procedures to comply with food safety regulations. In addition, the FDA has authority to require the submission and implementation of a risk evaluation and mitigation strategy ("REMS") if the FDA determines that that a REMS is necessary for the safe and effective marketing of a drug. To the extent we dispense products subject to REMS requirements or provide REMS services to pharmaceutical manufacturers, we are subject to audit by the FDA and the pharmaceutical manufacturer. The FDA also has regulatory authority over medical devices such as OTC genetic tests and genetic tests conducted by medical laboratories, and the FDA continues to evaluate the need for further regulation of such tests.

Federal Employee Health Benefits Program - We have a contractual arrangement with the BlueCross BlueShield Association ("BCBSA") to provide pharmacy services to federal employees, postal workers, annuitants, and their dependents under the Government-wide Service Benefit Plan, as authorized by the Federal Employees Health Benefits Act ("FEHBA") and as part of the Federal Employees Health Benefits Program ("FEHBP"). This arrangement subjects us to FEHBA, FEHBA regulations, including the Federal Employees Health Benefits Acquisition Regulation, the Office of Personnel Management guidelines, and certain Federal Acquisition Regulations. These laws, regulations and guidelines govern the process by which the federal government contracts with health insurance carriers, such as BCBSA, that participate in the FEHBP, and obligate such health insurance carriers to impose various contractual requirements on their contract vendors, including, among other things, requirements relating to transparency, performance standards, drug interchanges, patient safety, consumer access, coordination of benefits, pricing adjustments, recordkeeping and audits.

Formulary Regulation - A number of states regulate the administration of prescription drug benefits. For example, some states have passed laws mandating coverage for off-label uses of drug products where those uses are recognized in peer-reviewed medical journals or reference compendia. Other states have enacted laws that regulate the development and use of formularies by insurers, MCOs and other third party payors. These laws have included requirements on the development, review and update of formularies, the role and composition of pharmacy and therapeutics committees, the disclosure of formulary information to health plan members, and a process for allowing members to obtain non-preferred drugs without additional cost-sharing when they are medically necessary and are determined to be clinically appropriate. Additionally, the National Association of Insurance Commissioners ("NAIC") has developed a model law, the "Health Carriers Prescription Drug Benefit Management Model Act," that addresses formulary regulation issues for risk-bearing entities regulated by state insurance commissioners and could form the basis of state legislation. The MMA also regulates how formularies are developed for and administered to beneficiaries of Medicare Part D. In July 2008, Congress enacted the Medicare Improvements for Patients and Providers Act which requires the Secretary for HHS to identify certain classes and categories of drugs for which, subject to certain exceptions, all the drugs in any such class or category must be included in a Medicare Part D plan's formulary. ACA's Essential Health Benefits Rule will also regulate how prescription drugs are covered and how formularies are developed for and administered by state-based or federal health insurance exchanges established pursuant to ACA. These exchanges must begin enrolling consumers into coverage on October 1, 2013 and become fully operational on January 1, 2014. The increasing government regulation of formularies could significantly affect our ability to develop and administer formularies on behalf of our insurer, MCO and other clients.

Government Agreements and Mandates - Our PBM business is subject to the terms of a 2008 consent order entered into with a number of states impacting certain of our PBM business practices, including matters relating to our relationships with clients, pharmaceutical manufacturers, retail pharmacies, plan members, prescribers and pharmacists.

In March 2008, the Company entered into a settlement agreement with the federal government and a number of states related to the dispensing of the generic drug ranitidine at its retail pharmacies. At the same time, the Company entered into a corporate integrity agreement with the OIG for a period of five years applicable to certain retail and mail service operations of the Company. This 2008 corporate integrity agreement requires, among other things, maintenance of our compliance program, employee training, specific reviews by an independent review organization and various government reporting obligations. In April 2011, we entered into an amendment of the corporate integrity agreement in connection with the previously announced settlement of a federal and state government investigation of certain retail pharmacy billing practices with respect to "dual eligible" customers having both Medicaid coverage and other third-party insurance coverage. This amendment requires the Company to comply with the corporate integrity agreement, as amended, for a period of three years and further requires, among other things, additional employee training obligations, additional reporting obligations and periodic Medicaid billing reviews by an independent review organization. Failure to meet our obligations under this corporate integrity agreement, as amended, could result in stipulated financial penalties, and failure to comply with material terms could lead to exclusion of our applicable business from participation in federal health care programs.

In January 2009, we entered into separate settlement agreements with the FTC and the HHS Office for Civil Rights ("OCR") resolving a joint investigation prompted by 2006 media reports of disposal of patient information in dumpsters at a limited number of CVS/pharmacy locations. As part of the FTC settlement, we agreed to maintain appropriate enterprise-wide information security policies and procedures during the twenty-year term of the agreement. The FTC settlement also provides for periodic compliance monitoring by an external assessor. As part of the OCR settlement, we agreed to maintain appropriate waste disposal policies and procedures, training and employee sanctions at our retail stores. The OCR settlement provides for annual compliance monitoring by an external assessor.

In October 2010, the Company entered into a non-prosecution agreement and civil settlement agreement with the U.S. Department of Justice ("DOJ") and various United States Attorneys' Offices relating to the sale and distribution of pseudoephedrine products at certain CVS/pharmacy stores, primarily in California and Nevada. The Company also entered into a related memorandum of agreement with the DEA. The non-prosecution agreement and the memorandum of agreement contain certain ongoing compliance requirements for the Company, and failure to comply with the terms of these documents could lead to civil or criminal remedies, financial penalties and/or administrative remedies against the DEA registrations for our retail pharmacies and distribution centers.

In May 2012, a previously announced proposed consent order between the FTC and the Company became final and concluded an FTC investigation of the Company that commenced in 2009. The final consent order prohibits the Company from misrepresenting the price or cost of Medicare Part D prescription drugs or other prices or costs associated with Medicare Part D prescription drug plans.

On October 12, 2012, the DEA Administrator published its Final Decision and Order revoking the DEA license registrations for dispensing controlled substances at two of our retail pharmacy stores in Sanford, Florida. The license revocations for the two stores formally became effective on November 13, 2012. The pharmacies previously had voluntarily suspended dispensing controlled substances since April 2012, and have continued operating in that manner in compliance with the DEA Order.

In addition to the government agreements described above, the Company and/or its various affiliates are subject to other consent decrees or settlement agreements with various federal, state and local authorities that may contain certain ongoing reporting, monitoring or other compliance requirements for the Company. These agreements relate to such matters as privacy practices, waste disposal practices, selling expired products, environmental and safety matters, tobacco sales, marketing and advertising practices, pharmacy operations and various other business practices.

Health Reform Legislation - Congress passed major health reform legislation in 2010 known as ACA. This legislation affects the entire health insurance system and virtually every aspect of health care in the country, although many provisions of ACA were not effective immediately. In addition to establishing the framework for every individual to have health coverage beginning in 2014, ACA enacted a number of significant health care reforms. While these reforms may not affect our business directly, they affect the coverage and plan designs that are or will be provided by many of our health plan clients. As a result, they could indirectly impact many of our services and business practices. Given that many of the regulations implementing ACA are still being finalized and that ongoing sub-regulatory guidance is still being issued, there is considerable uncertainty as to its full impact.

Among the more significant ACA provisions is the requirement for health insurers to meet a minimum medical loss ratio ("MLR") to avoid having to pay rebates to enrollees. The MLR requires insurers to break out clinical, quality improvement and administrative costs. HHS issued an interim final regulation on the MLR in December 2010 that includes an example that could be interpreted to suggest that the differential between the drug price charged by PBMs to health plans and the amount reimbursed to retail pharmacies (commonly referred to as "differential" or "spread") should be excluded from claims costs. Subsequent sub-regulatory guidance remained consistent with this interpretation, although it made clear that clinical services performed by a PBM could be included in claims costs. Health plan clients that are subject to the MLR requirements may request pricing modifications, include requests to contract with our PBM using pass-through retail network pricing.

Another ACA provision requires PBMs that contract with a Medicare Part D plan or a qualified health plan offered through a health insurance exchange to disclose certain information to HHS, the Medicare Part D plan or the health insurance exchange. Among the information that must be disclosed is the generic dispensing rate for different types of pharmacies, the aggregate amount and types of rebates and other discounts negotiated on behalf of, and passed through to, the plan, and the aggregate amount of any differential. A final rule requiring this reporting for Medicare Part D was issued in April 2012 and reporting for qualified health plans is expected in 2014 upon the implementation of the health insurance exchanges to be established under ACA. ACA also increases the obligations of Part D plan sponsors to report rebates and other price concessions from pharmaceutical manufacturers to enable calculation of new annual fees being imposed on pharmaceutical manufacturers related to branded drug sales. ACA also made significant changes to the Medicare and Medicaid programs, fraud and abuse laws and tax provisions, some of which are discussed elsewhere in this Government Regulation section.

Managed Care Reform - In addition to health reforms enacted by ACA, proposed legislation has been considered at the state level, and legislation has been enacted in several states, aimed primarily at providing additional rights and access to drugs to individuals enrolled in managed care plans. This legislation may impact the design and implementation of prescription drug benefit plans

sponsored by our PBM health plan clients and/or the services we provide to them. Some of these initiatives would, among other things: (i) require that health plan members have greater access to drugs not included on a plan's formulary; (ii) give health plan members the right to sue their health plans for malpractice if they have been denied care; and/or (iii) mandate the content of the appeals or grievance process when a health plan member is denied coverage. Both the scope of the managed care reform proposals considered by state legislatures and reforms enacted by states to date vary greatly, and the scope of future legislation that may be enacted is uncertain.

Medicare Part D - The MMA created Medicare Part D, the Medicare drug benefit program, in January 2006. Medicare beneficiaries entitled to Medicare benefits under Part A or enrolled in Medicare Part B are eligible for drug coverage under Medicare Part D. Regulations implementing Medicare Part D included requirements relating to developing and administering formularies, establishing pharmacy networks, marketing of Medicare Part D plans, processing and adjudicating claims at point of sale and compliance with electronic prescribing standards. The Medicare Part D program has undergone significant legislative and regulatory changes since its inception, including changes made by ACA. Effective for the 2010 plan year, CMS issued a regulation requiring that any "differential" or "spread" be reported as an administrative cost rather than a drug cost of the plan sponsor for purposes of calculating certain government subsidy payments and the drug price to be charged to enrollees. This change resulted in Medicare Part D plan sponsors contracting for pass-through pricing for their retail networks rather than pricing that included the use of retail network "differential" or "spread".

ACA expanded the Medicare Part D benefit effective for the 2011 plan year by implementing the coverage gap discount program under which participating manufacturers fund discounts of 50% on brand drugs obtained during the coverage gap or "donut hole," and starting the phase-out of the coverage gap for generic drugs, which is to be completed by 2020.

ACA also requires the Secretary of HHS to develop rules for shorter dispensing periods for enrollees in long-term care facilities in order to reduce waste. Several of the ACA changes will require significant adjudication and reporting systems modifications. In April 2012, CMS issued a final rule on Medicare Part D that, among other things, would establish a daily cost sharing rate as a form of drug utilization management and certain fraud, waste and abuse controls. The rule also permits CMS to terminate a Medicare Part D sponsor's contract if it fails to achieve at least a 3-star plan rating for three consecutive years. Finally, the rule provides that, beginning on January 1, 2013, employer group waiver plan ("EGWP") supplemental benefits to basic Medicare Part D coverage must be treated as other health or prescription drug coverage and a non-Medicare benefit. CMS has since announced that it is delaying the implementation of this change in the definition of Medicare Part D supplemental benefits until 2014 in order to develop guidance to address the policy implications of this change, including the applicability of other state and federal laws.

Medicare Part D continues to attract a high degree of legislative and regulatory scrutiny, and the applicable government rules and regulations continue to evolve. Accordingly, it is possible that legislative and regulatory developments could materially affect our Medicare Part D business or profitability.

Mental Health Parity Legislation - The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and its implementing regulations require group health plans that provide both medical/surgical benefits and mental health or substance abuse disorder benefits to ensure that the financial requirements and treatment limitations that apply to the mental health and substance abuse disorder benefits are no more restrictive than those that apply to the medical/surgical benefits. While the implementing regulations contain a special rule allowing for "multi-tiered prescription drug benefits" that meet certain conditions, there is considerable uncertainty regarding the application of this rule. This has caused some group health plans to consider dropping mental health benefits, including drugs that treat these conditions, to avoid being found in violation of the regulation.

Network Access Legislation - A majority of states now have some form of legislation affecting the ability to limit access to a pharmacy provider network or remove network providers. Certain "any willing provider" legislation may require us or our clients to admit a non-participating pharmacy if such pharmacy is willing and able to meet the plan's price and other applicable terms and conditions for network participation. These laws vary significantly from state to state in regard to scope, requirements and application. ERISA plans and payors have challenged the application of such laws on the basis of ERISA preemption. However, the scope of ERISA preemption is uncertain and is subject to conflicting court rulings. In addition, the MMA contains an "any willing provider" requirement for pharmacy participation in Medicare Part D, and CMS has interpreted this as requiring that a Medicare Part D sponsor, for each type of pharmacy in its network, allow participation by any pharmacy that meets the applicable terms and conditions for participation. To the extent any state or federal any willing provider laws are determined to apply to us or to certain of our clients or to the pharmacy networks we manage for our PBM clients, such laws could negatively impact the services and economic benefits achievable through a limited pharmacy provider network.

Some states also have enacted "due process" legislation that may (i) prohibit the removal of a provider from a pharmacy network and/or (ii) impact how we conduct audits of network pharmacies and recover audit discrepancies, except in compliance with certain procedures. Other state legislation prohibits days' supply limitations or co-payment or other pricing differentials between mail service and retail pharmacy providers. In addition, under Medicare Part D, CMS requires that if a Medicare Part D sponsor offers a 90-day supply at mail, it must allow retail network pharmacies to also offer a 90-day supply on the same terms.

PBM Laws and Regulation - Legislation seeking to regulate PBM activities in a comprehensive manner has been introduced or enacted in a number of states. This legislation varies in scope and often contains provisions that: (i) impose certain fiduciary duties upon PBMs to clients and plan members; (ii) require PBMs to disclose and/or remit to clients or their plan members certain rebates, discounts and other amounts received by PBMs related to the sale of drugs; (iii) regulate product substitution and intervention; (iv) impose broad disclosure obligations upon PBMs to clients and their plan members and/or (v) impose licensing or registration requirements. To the extent states or other government entities enact legislation regulating PBMs that survive legal challenges to their enforceability, such legislation could adversely impact our ability to conduct business on commercially reasonable terms in locations where the legislation is in effect.

In addition, certain quasi-regulatory organizations, including the National Association of Boards of Pharmacy and the NAIC have issued model regulations or may propose future regulations concerning PBMs and/or PBM activities. Similarly, credentialing organizations such as the National Committee for Quality Assurance and the Utilization Review Accreditation Commission ("URAC") may establish voluntary standards regarding PBM or specialty pharmacy activities. For example, URAC has issued PBM accreditation standards for PBMs serving the commercially insured market, and Caremark is currently accredited as a PBM by URAC. While the actions of these quasi-regulatory or standard-setting organizations do not have the force of law, they may influence states to adopt their requirements or recommendations and influence client requirements for PBM or specialty pharmacy services. Moreover, any standards established by these organizations could also impact our health plan clients and/or the services we provide to them.

In addition to state statutes and regulations, we are also subject to state common laws to the extent applied to PBMs through judicial interpretation or otherwise. Potential common law claims could involve, for example, breach of fiduciary duty, constructive fraud, fraud or unjust enrichment.

Pharmacy and Professional Licensure and Regulation - We are subject to state and federal statutes and regulations governing the operation of retail and mail pharmacies, the transfer of prescriptions, repackaging of drug products, wholesale distribution, dispensing of controlled substance and listed chemical products, and medical and controlled substance waste disposal. Federal and state statutes and regulations govern the labeling, packaging, advertising and adulteration of prescription drugs and the dispensing of controlled substances, and some state regulations require compliance with standards established by the United States Pharmacopeia with respect to the packaging, storing and shipping of pharmaceuticals. Federal and state controlled substance laws require us to register our pharmacies and distribution centers with the DEA and state controlled substances agencies and to comply with security, recordkeeping, inventory control, personnel and labeling standards in order to possess and dispense controlled substances and listed chemical products.

We also are subject to regulation by the DEA and state pharmacy boards in connection with our online pharmacies because we dispense prescription drugs pursuant to refill orders received through our Internet websites, among other methods. Numerous state laws also exist affecting our receipt and processing of electronic prescription drug orders.

Certain violations of the federal controlled substances laws can subject the Company, its pharmacies and distribution centers, and individual pharmacy personnel to criminal and civil penalties and can also result in administrative action by the DEA, including suspension or revocation of a pharmacy's or distribution center's registration to distribute controlled substances and/or listed chemical products. State authorities and state boards of pharmacy similarly have the authority to impose both monetary penalties and disciplinary sanctions, including revocation of a pharmacy's or individual pharmacist's license to dispense controlled substances, and these penalties and sanctions are in addition to sanctions imposed under the federal controlled substances laws. Certain violations of these federal and state legal requirements can also trigger other consequences for the Company's business and could potentially impact our eligibility to participate in federal health care programs.

Other statutes and regulations may affect our mail service operations. For example, the FTC requires mail service sellers of goods generally to engage in truthful advertising, to stock a reasonable supply of the products to be sold, to fill mail service orders within thirty days and to provide clients with refunds when appropriate. In addition, the United States Postal Service and the Department of Transportation each has regulatory authority to restrict the transmission of drugs and medicines through the mail or in commerce, and state licensing authorities may restrict the types of personnel who may work in mail service operations.

Our pharmacists, technicians and certain other health care professionals are subject to state regulation of their profession, and our employees who are engaged in a professional practice must satisfy applicable state licensing or registration requirements and comply with applicable professional standards. In addition, they must comply with any applicable federal or state requirements for participation in government-sponsored health care programs. Failure to comply with these requirements could subject us and our employees to disciplinary action, including fines, penalties or sanctions, could impact our ability to obtain or retain reimbursement for services provided to participants of government-sponsored health care programs and/or could cause our licenses and permits and our employees' licenses to be suspended or revoked.

Plan Design Legislation - Some states have enacted legislation that prohibits a health plan sponsor from implementing certain restrictive design features, and many states have introduced legislation to regulate various aspects of managed care plans, including

provisions relating to pharmacy benefits. For example, some states have adopted "freedom of choice" legislation, which provides that: (i) members of a plan may not be required to use network providers but must instead be provided with benefits even if they choose to use non-network providers or (ii) a plan member may sue his or her health plan if care is denied. Various states have enacted, or have considered enacting, legislation regarding plan design mandates, including legislation that prohibits or restricts therapeutic interchange, requires coverage of all drugs approved by the FDA or prohibits denial of coverage for non-FDA approved uses. Some states mandate coverage of certain benefits or conditions, and ACA requires the coverage of certain preventive services at no cost sharing. Such legislation does not generally apply to us, but it may apply to certain of our clients (generally, MCOs and health insurers). Other states have enacted legislation purporting to prohibit health plans not covered by ERISA from requiring or offering members financial incentives for use of mail service pharmacies or for use of certain health care providers. Legislation imposing plan design mandates may apply to certain of our clients and could have the effect of limiting the economic benefits achievable through PBM services we provide.

Privacy and Confidentiality Requirements - Many of our activities involve the receipt, use and disclosure by us of personally identifiable information ("PII") as permitted in accordance with applicable federal and state privacy and data security laws, which require organizations to provide appropriate privacy protections and security safeguards for such information. In addition to PII, we use and disclose de-identified data for analytical and other purposes.

The federal Health Insurance Portability and Accountability Act of 1996 and the regulations issued thereunder (collectively "HIPAA") impose extensive requirements on the way in which health plans, health care providers, health care clearinghouses (known as "covered entities") and their business associates use, disclose and safeguard protected health information ("PHI"). HIPAA also gives individuals certain rights with respect to their PHI. For most uses and disclosures of PHI other than for treatment, payment, health care operations or certain public policy purposes, HIPAA generally requires that covered entities obtain the individual's written authorization. Criminal penalties and civil sanctions may be imposed for failing to comply with HIPAA standards.

In January 2013, HHS issued a final Omnibus Rule to covered the rulemaking required by the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), enacted as part of ARRA, to address significant changes to the HIPAA privacy and security rules. The rule addresses restrictions on the use of PHI without an individual's written authorization, requirements to update a covered entity's notice of privacy practices, a requirement to account for routine disclosures of PHI held in an electronic health record, a requirement to notify individuals of breaches to their PHI, requirements limiting how a covered entity may receive financial remuneration to make communications to patients, requirements to enforce HIPAA Privacy and Security Rules on business associates and their subcontractors, enforcement rights of state attorneys general, extension of the federal privacy and security law provisions and penalties to business associates of covered entities, and increased penalties for violation of the law. The effective date of this new rule is March 26, 2013, and covered entities and business associates must comply with the applicable requirements by September 23, 2013. This rule did not address changes to the requirements surrounding the accounting of disclosures to an individual of all internal uses and disclosures of electronic PHI, which were previously addressed in the May 2011 Notice of Proposed Rulemaking ("NPRM"). If HHS adopts the NPRM as currently written, it could generate substantial burdens and costs for the Company and our business associates to implement fully. Nevertheless, since the Omnibus Rule has just been issued and the NPRM is not in final form, we cannot at this time determine the full extent to which these changes may apply to, or impact, our business.

In addition to HIPAA, most states have enacted health care information confidentiality laws which limit the disclosure of confidential medical information. These state laws supersede HIPAA to the extent they are more protective of individual privacy than is HIPAA. Most states have also enacted legislation and regulations governing the security of PII and specifying notification requirements for any security breaches involving PII.

The Genetic Information Nondiscrimination Act ("GINA") was signed into law in May 2008, and proposed and interim final regulations were issued under it in 2009 and 2010. GINA prohibits discrimination based on genetic information in health coverage (Title I) and employment (Title II). Under GINA, health plans are not permitted to use or disclose genetic information for underwriting purposes, which includes eligibility determinations. They also may not collect genetic information, such as by requiring genetic testing, except in very limited circumstances.

In March 2012, the FTC issued a final report setting forth best practices for businesses to protect the privacy of consumers and to give them greater control over the collection and use of PII. In this report, the FTC recommends that companies handling consumer data implement measures to increase the security of PII, to enable consumers to choose how their PII is shared and to promote transparency about how PII is collected and used. The report also recommends that Congress enact additional privacy-related legislation, even though it has not yet done so.

Reimbursement - A significant portion of our net revenue is derived directly from Medicare, Medicaid and other government-sponsored health care programs, and we are therefore subject to, among other laws and regulations, federal and state reimbursement laws and regulatory requirements, anti-remuneration laws, the Stark Law and/or federal and state false claims laws. (See the "Self-Referral Laws" section below for explanation of the Stark Law.) Sanctions for violating these federal and/or state laws may include,

without limitation, recoupment or reduction of government reimbursement amounts, criminal and civil penalties and exclusion from participation in Medicare, Medicaid and other government health care programs. Also, we provide products and services to managed care entities that provide services to beneficiaries of Medicare, Medicaid and other government-sponsored health care programs, as well as employers and other entities that qualify for the Medicare Part D drug subsidy and/or the early retiree reinsurance program created under ACA. Some of these federal and state laws and regulations impose requirements on our PBM and our retail pharmacies to coordinate benefits among private health plans and government-sponsored health care programs when a customer or plan member has benefits coverage through more than one insurance company or other payor. In addition, our PBM has contractual agreements to process, on behalf of PBM clients, reimbursement claims submitted by or on behalf of federal and state government agencies following payment by the government agencies of claims that should have been submitted by members to private health plans as the primary source of benefits coverage. These claims are commonly known as "pay and chase" claims, and we and our PBM clients are subject to federal and state laws and regulations impacting how these claims are processed and reimbursed. See Item 3, "Legal Proceedings," for further information.

The federal government and numerous state governments have given increased attention to how pharmaceutical manufacturers develop and report pricing information, which, in turn, is used in setting payments under the Medicare and Medicaid programs. One element common to most payment formulas, Average Wholesale Price ("AWP"), has come under criticism for allegedly inaccurately reflecting prices actually charged and paid at the wholesale level. The calculation and reporting of AWP have been the subject of investigations by federal and state governments and litigation brought against pharmaceutical manufacturers and data services that report AWP. We are not responsible for calculations, reports or payments of AWP; however, such investigations or lawsuits could impact our business because many of our client contracts, pharmaceutical purchase agreements, retail network contracts and other agreements use AWP as a pricing benchmark. In conjunction with a class action settlement implemented in September 2009 involving First DataBank ("FDB") and Medi-Span, two entities that publish the AWP of pharmaceuticals, the methodology used to calculate AWP was modified in a manner that reduced AWP for many brand drugs and some generic drugs. We have reached understandings with most of our PBM clients and other third party payors to adjust reimbursements to account for this change in methodology, but most state Medicaid programs that utilize AWP as a pricing reference have not taken action to make similar adjustments. As a result, we have experienced reduced Medicaid reimbursement for certain products since the settlement was implemented. In addition, FDB discontinued the publishing of AWP in September 2011. Although Medi-Span continues to publish AWP, it is possible that the pharmaceutical industry may evaluate and/or develop an alternative pricing reference to replace AWP. We will continue to work with our PBM clients and other payors to anticipate and mitigate the impact of possible future changes to applicable references for pricing pharmaceuticals. AWP has already been replaced by Average Sales Price ("ASP") as the basis for reimbursing physicians, and sometimes pharmacies, for outpatient prescription drugs under Medicare Part B.

The federal Medicaid rebate program requires participating drug manufacturers to provide rebates on all drugs purchased by state Medicaid programs. Investigations have commenced by certain governmental entities that question whether the best price available to essentially any client other than the Medicaid program, or "best price," was properly calculated, reported and paid by the manufacturers to the Medicaid programs. We are not responsible for calculations, reports or payments of "best price"; however, these investigations could impact our ability to negotiate rebates from drug manufacturers. ACA increased the amount of rebates required to be paid by manufacturers under the Medicaid program and also imposes certain annual fees on pharmaceutical manufacturers. We do not anticipate the increased Medicaid rebate levels or the annual fees to impact the discounts we obtain from pharmaceutical companies.

ACA made several other significant changes to the Medicaid rebates and to reimbursement. One of these was to revise the definition of Average Manufacturer Price ("AMP") and the reimbursement formula for multi-source (i.e., generic) drugs, which is based on Federal Upper Limits ("FUL") established by CMS. In February 2012, CMS issued a proposed rule to interpret and implement these changes. CMS is proposing to set the FUL for multi-source drug reimbursement at 175% of AMP. The FUL would be established for each multi-source drug for which the FDA has rated three or more products therapeutically and pharmaceutically equivalent and would be based on the weighted average of the most recently reported monthly AMPs for such products. Among other things, the proposed CMS rule also proposes changes to Medicaid drug reimbursement payment methodologies and to Medicaid best price regulations. It is uncertain as to what extent these proposed changes may impact Medicaid reimbursement rates. CMS has stated that it intends to issue a final rule in 2013. Because of the proposed status of the rule, we cannot yet predict the impact of the proposed rule on the Company. CMS issued and solicited comments on a draft AMP-based FUL and draft three-month rolling average FUL files, and has stated that after it considers comments on these draft files and certain other draft drug pricing, it will release these data files in final form and post updated files on at least a monthly basis. These finalized files may then be used by states, depending on the approved state plan, to develop a pharmacy reimbursement methodology that will allow their pharmacy payments to remain within the FUL in the aggregate. CMS has not provided guidance on when the final FUL will be published.

Certain state Medicaid programs only allow for reimbursement to pharmacies residing in the state or in a border state. While we believe that we can service our current Medicaid customers through our existing pharmacies, there can be no assurance that additional states will not enact in-state dispensing requirements for their Medicaid programs. Some states have adopted legislation and regulations requiring that a pharmacy participating in the state Medicaid program give the state the "best price" that the pharmacy

makes available to any third party payor, and some states have enacted legislation and regulations impacting the definition of a pharmacy's "usual and customary" price (U&C), including whether pricing offered by pharmacies pursuant to discount card or similar programs should be considered in determining U&C. These requirements are sometimes referred to as "most favored nation pricing" payment systems. Other states have enacted "unitary pricing" legislation, which mandates that all wholesale purchasers of drugs within the state be given access to the same discounts and incentives. A number of states have also recently introduced legislation seeking to control drug prices through various statutory limits, rebates or discounts extending to one or more categories of the state's population.

Changes in reporting of AWP, AMP, ASP or other adjustments that may be made regarding the reimbursement of drug payments by Medicaid and Medicare could impact our pricing to customers and other payors and/or could impact our ability to negotiate discounts or rebates with manufacturers, wholesalers, PBMs or retail and mail pharmacies. In some circumstances, such changes could also impact the reimbursement that we receive from Medicare or Medicaid programs for drugs covered by such programs and from MCOs that contract with government health programs to provide prescription drug benefits.

Reimportation - The MMA amended the Food, Drug and Cosmetic Act by providing that the FDA should promulgate rules that would permit pharmacists and wholesalers to import prescription drugs from Canada into the United States under certain circumstances. However, the promulgation of such rules is subject to a precondition that the FDA certify to Congress that such reimportation would not pose any additional risk to the public's health and safety and that it would result in a significant cost reduction. To date, the FDA has not provided such a certification. Under certain defined circumstances, the FDA has used its discretion to permit individuals and their physicians to bring into the U.S. small quantities of drugs for treatment of a patient's serious condition for which effective treatment is not available in the U.S. Congress then expanded this personal use policy in very specific circumstances to allow individuals to personally transport from Canada for their personal use a 90-day supply of any prescription drug, regardless of availability in the U.S. The language does not allow purchases by mail order or via the Internet, and excludes biologics and controlled substances. The FDA continues to strongly oppose efforts to allow the widespread importation of drugs from Canada and elsewhere, citing concerns that such activities undermine the FDA's ability to oversee the quality and safety of the nation's drug supply. If the FDA changes its position and permits the broader importation of drugs from Canada in the future, or if new or pending health legislation or regulations permit the importation of drugs from the European Union or other countries in the future, our pharmacy services could be impacted.

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

Retiree Drug Subsidy - The MMA created a drug subsidy program available to certain employer, union and other group plans that provide retiree coverage to Medicare Part D eligible individuals that is at least equivalent to Medicare Part D coverage. The subsidy is equal to 28% of drug costs, and is currently tax-free. However, for plan years beginning in 2013, ACA eliminates the tax deductibility of the retiree drug subsidy payment received by sponsors of retiree drug plans. This may cause some employers to transition their retirees to employer-sponsored Medicare Part D plans.

Safety Regulations - The Occupational Safety and Health Act of 1970, as amended ("OSHA"), establishes certain employer responsibilities, including maintenance of a workplace free of recognized hazards likely to cause death or serious injury, compliance with standards promulgated under OSHA, and various record keeping, reporting and procedural requirements. Many of these OSHA standards, as well as various state and local laws and regulations pertaining to employee safety and health, including some that apply specifically to healthcare employees, apply to our operations. Any failure to comply with these regulations could result in fines or other sanctions by government authorities.

Self-Referral Laws - The federal law commonly known as the "Stark Law" prohibits a physician from referring Medicare or Medicaid beneficiaries for "designated health services" (which include, among other things, outpatient prescription drugs, home health services and durable medical equipment and supplies) to an entity with which the physician or an immediate family member of the physician has a "financial relationship" and prohibits the entity receiving a prohibited referral from presenting a claim to Medicare or Medicaid for the designated health service furnished under the prohibited referral. Possible penalties for violation of the Stark Law include denial of payment, refund of amounts collected in violation of the statute, civil monetary penalties and Medicare and Medicaid program exclusion. The Stark Law contains certain statutory and regulatory exceptions for physician referrals and physician financial relationships, including certain physician consulting arrangements, fair market value purchases by physicians and, in certain cases, the provision of electronic prescribing technology to physicians.

State statutes and regulations also prohibit payments for the referral of individuals by physicians to health care providers with whom the physicians have a financial relationship. Some of these state statutes and regulations apply to services reimbursed by governmental as well as private payors. Violation of these laws may result in prohibition of payment for services rendered, loss of pharmacy or health care provider licenses, fines and criminal penalties. The laws and exceptions or safe harbors may vary from the federal Stark

Law and vary significantly from state to state. The laws are often vague, and, in many cases, have not been interpreted by courts or regulatory agencies.

State Insurance Laws - Fee-for-service PDPs and our PBM service contracts, including those in which we assume certain risk under performance guarantees or similar arrangements, are generally not subject to insurance regulation by the states. However, if a PBM offers to provide prescription drug coverage on a capitated basis or otherwise accepts material financial risk in providing pharmacy benefits, laws and regulations in various states may be applicable. 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.

During 2012, the Company offered PDPs through its SilverScript and Pennsylvania Life insurance subsidiaries. These insurance subsidiaries each must be licensed as a risk-bearing entity under applicable state laws or they must have obtained a waiver of the licensing requirement from CMS. Each of these subsidiaries is licensed in all states in which they offer PDPs and do not operate under any Medicare Part D waivers. As licensed insurance companies, they are subject to various state insurance regulations that generally require, among other things, maintenance of capital and surplus requirements, review of certain material transactions and the filing of various financial, licensing and operational reports. Pursuant to the MMA, state insurance licensing, insurance agent/broker licensure and solvency laws and regulations are generally applicable to PDPs, but the application of other state laws to Medicare Part D is generally preempted by Medicare Part D to the extent that Medicare Part D regulates the issue.

Some states have laws that prohibit submitting a false claim or making a false record or statement in order to secure reimbursement from an insurance company. These state laws vary, and violation of them may lead to the imposition of civil or criminal penalties. Additionally, several states have passed legislation governing the prompt payment of claims that requires, among other things, that health plans and payors pay claims within certain prescribed time periods or pay specified interest penalties. These laws vary from state to state in regard to scope, requirements and application, and it is not clear the extent to which they may apply to our clients or to us. Certain health plans and payors may be exempt from such laws on the basis of ERISA preemption, but the scope of ERISA preemption is unclear.

State Prescription Drug Assistance Programs - Many states have established or modified their drug assistance programs for the elderly so that they constitute qualified state pharmacy assistance programs (“SPAPs”) that supplement Medicare Part D. Payments by qualified SPAPs on behalf of a Medicare Part D enrollee are treated under Medicare Part D as if they were made by the enrollees themselves, thereby counting towards the enrollees’ true out-of-pocket costs and helping them qualify for catastrophic coverage sooner. Medicare Part D plans are required to coordinate benefits with SPAPs, including allowing SPAPs to subsidize the Medicare Part D premiums of their members and/or their Medicare Part D cost sharing. Some qualified SPAPs with state authorization have also received permission from CMS to enroll members who do not choose their own Medicare Part D plans into PDPs.

Telemarketing and Other Outbound Contacts - Certain federal and state laws give the FTC, Federal Communications Commission and state attorneys general law enforcement tools to regulate telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. These laws may, among other things, impose registration requirements, require disclosures of specific information, prohibit misrepresentations, limit when, where and how consumers may be contacted, require consumer consent prior to being contacted, require transmission of Caller ID information, prohibit certain abandoned outbound calls, prohibit unauthorized billing, set payment restrictions for the sale of certain goods and services, require the establishment of certain policies and training of personnel and require the retention of specific business records.

Third Party Administration and Other State Licensure Laws - Many states have licensure or registration laws governing certain types of administrative organizations, such as preferred provider organizations, third party administrators and companies that provide utilization review services. Several states also have licensure or registration laws governing the organizations that provide or administer consumer card programs (also known as cash card or discount card programs). The scope of these laws differs significantly from state to state, and the application of such laws to our activities often is unclear.

Whistleblower Statutes - Certain federal and state laws, including the FCA, contain provisions permitting the filing of *qui tam* or “whistleblower” lawsuits alleging violations of such laws. Whistleblower provisions allow private individuals to bring lawsuits on behalf of the federal or state government alleging that the defendant has defrauded the government, and there is generally no minimum evidentiary or legal threshold required for bringing such a lawsuit. These lawsuits are typically filed under seal with the applicable federal or state enforcement authority, and such authority is required to review the allegations made and to determine whether it will intervene in the lawsuit and take the lead in the litigation. If the government intervenes in the lawsuit and prevails, the whistleblower plaintiff filing the initial complaint may share in any settlement or judgment. If the government does not intervene in the lawsuit, the whistleblower plaintiff may pursue the action independently. Because a *qui tam* lawsuit typically is filed under seal pending a government review of the allegations, the defendant generally may not be aware of the lawsuit until the government determines whether or not it will intervene or until the lawsuit is otherwise unsealed, a process which may take years. See Item 3, “Legal Proceedings,” for further information.

We believe that we are in material compliance with existing laws and regulations applicable to our retail and PBM businesses. We have implemented standard operating procedures, internal controls and a compliance and integrity program designed to help ensure such compliance, and we monitor legislative and judicial developments that could impact our business practices in an effort to ensure future compliance.

We can give no assurance, however, that our business, financial condition and results of operations will not be materially adversely affected, or that we will not be required to materially change our business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations, including the laws and regulations described in this Government Regulation section, as they may relate to our business, the pharmacy services, retail pharmacy or retail clinic industry or to the health care industry generally; (iii) pending or future federal or state governmental investigations of our business or the pharmacy services, retail pharmacy or retail clinic industry or of the health care industry generally; (iv) institution of government enforcement actions against us; (v) adverse developments in any pending *qui tam* lawsuit against us, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against us; or (vi) adverse developments in other pending or future legal proceedings against us or affecting the pharmacy services, retail pharmacy or retail clinic industry or the health care industry generally.

Available Information

CVS Caremark Corporation is a Delaware corporation. Our corporate office is located at One CVS Drive, Woonsocket, Rhode Island 02895, telephone (401) 765-1500. Our common stock is listed on the New York Stock Exchange under the trading symbol "CVS." General information about CVS Caremark is available through the Company's Web site at *http://info.cvscaremark.com*. Our financial press releases and filings with the U.S. Securities and Exchange Commission ("SEC") are available free of charge within the Investors section of our Web site at *http://www.cvscaremark.com/investors*. In addition, the SEC maintains an internet site that contains reports, proxy and information statements and other information regarding issuers, such as the Company, that file electronically with the SEC. The address of that Web site is *http://www.sec.gov*.

Item 1A. Risk Factors

Our business is subject to various industry, economic, regulatory and other risks and uncertainties. Our business, financial position and results of operations could be materially adversely affected by any one or more of the following risk factors and by additional risks and uncertainties not presently known to us or that we currently deem to be immaterial:

The health of the economy in general and in the markets we serve.

Our business is affected by the economy in general, including changes in consumer purchasing power, preferences and/or spending patterns. These changes could affect drug utilization trends as well as the financial health and number of covered lives of our PBM clients, resulting in an adverse effect on our business and financial results.

Although a recovery might be underway, it is possible that a worsening of the economic environment will cause decline in drug utilization, and dampen demand for pharmacy benefit management services as well as consumer demand for products sold in our retail stores. Further, interest rate fluctuations, changes in capital market conditions and regulatory changes may affect our ability to obtain necessary financing on acceptable terms, our ability to secure suitable store locations under acceptable terms and our ability to execute sale-leaseback transactions under acceptable terms.

Efforts to reduce reimbursement levels and alter health care financing practices.

The continued efforts of health maintenance organizations, managed care organizations, PBM companies, government entities, and other third party payors to reduce prescription drug costs and pharmacy reimbursement rates may impact our profitability. In particular, increased utilization of generic pharmaceuticals (which normally yield a higher gross profit rate than equivalent brand named drugs) has resulted in pressure to decrease reimbursement payments to retail and mail order pharmacies for generic drugs, causing a reduction in the generic profit rate. Historically, the effect of this trend on generic profitability has been mitigated by the Company's efforts to negotiate reduced acquisition costs of generic pharmaceuticals with manufacturers. However, in recent years, there has been significant consolidation within the generic manufacturing industry, and it is possible that this dynamic may enhance the ability of manufacturers to sustain or increase pricing of generic pharmaceuticals and diminish the ability of the Company to negotiate reduced acquisition costs.

In addition, during the past several years, the U.S. health care industry has been subject to an increase in governmental regulation at both the federal and state levels. Efforts to control health care costs, including prescription drug costs, are underway at the federal and state government levels. Changing political, economic and regulatory influences may significantly affect health care financing and reimbursement practices.

ACA made several significant changes to Medicaid rebates and to reimbursement. One of these changes was to revise the definition of AMP and the reimbursement formula for multi-source (i.e., generic) drugs. In February 2012, CMS issued a proposed rule to interpret and implement these changes. Among other things, the proposed CMS rule also proposes changes to Medicaid drug reimbursement payment methodologies and to Medicaid best price regulations, and the extent to which these proposed changes may impact Medicaid reimbursement rates remains uncertain. CMS has stated that it intends to issue a final rule in 2013. Because of the proposed status of the rule, we cannot yet predict its impact on the Company. In addition, ACA made other changes that affect the coverage and plan designs that are or will be provided by many of our health plan clients, including the requirement for health insurers to meet a minimum MLR to avoid having to pay rebates to enrollees. These ACA changes may not affect our business directly, but they could indirectly impact our services and/or business practices.

The possibility of PBM client loss and/or the failure to win new PBM business.

Our PBM business generates net revenues primarily by contracting with clients to provide prescription drugs and related health care services to plan members. PBM client contracts often have terms of approximately three years in duration, so approximately one third of a PBM's client base typically is subject to renewal each year. In some cases, however, PBM clients may negotiate a shorter or longer contract term or may require early or periodic renegotiation of pricing prior to expiration of a contract. Therefore, we face challenges in competing for new PBM business and retaining or renewing PBM business. None of our PBM clients represented more than 10% of our Company's consolidated revenues in 2012. There can be no assurance that we will be able to win new business or secure renewal business on terms as favorable to the Company as the present terms.

Risks related to the frequency and rate of the introduction of generic drugs and brand name prescription products.

The profitability of retail and mail order pharmacy businesses are dependent upon the utilization of prescription drug products. Utilization trends are affected by, among other factors, the introduction of new and successful prescription pharmaceuticals as well as lower-priced generic alternatives to existing brand name products. Accordingly, our business could be impacted by a slowdown in the introduction of new and successful prescription pharmaceuticals and/or generic alternatives (the sale of which normally yield higher gross profit margins than brand name equivalents).

Risks relating to the market availability, suppliers and safety profiles of prescription drugs that we purchase and sell.

We dispense significant volumes of brand-name and generic drugs from our retail and mail-order pharmacies and through our network of retail pharmacies. When increased safety risk profiles or manufacturing or other supply issues of specific drugs or classes of drugs occur, physicians may cease writing prescriptions for these drugs or the utilization of these drugs may be otherwise reduced. Additionally, adverse publicity regarding drugs with higher safety risk profiles may result in reduced consumer demand for such drugs. On occasion, products are withdrawn by their manufacturers or transition to over-the-counter products, which can result in changes in prescription utilization. In addition, future FDA rulings could restrict the supply or increase the cost of products sold to our customers. Our volumes, net revenues, profitability and cash flows may decline as a result of such market changes.

Risks of declining gross margins in the PBM industry.

The PBM industry has been experiencing margin pressure as a result of competitive pressures and increased client demands for lower prices, enhanced service offerings and/or higher service levels. In that regard, our Company maintains contractual relationships with generic pharmaceutical manufacturers and brand name pharmaceutical manufacturers that provide for purchase discounts and/or rebates on drugs dispensed by pharmacies in our retail network and by our mail order pharmacies (all or a portion of which may be passed on to clients). Manufacturer rebates often depend on a PBM's ability to meet contractual market share or other requirements, including in some cases the placement of a manufacturer's products on the PBM's formularies. Competitive pressures in the PBM industry have caused the Company's PBM and other PBMs to share with clients a larger portion of rebates and/or discounts received from pharmaceutical manufacturers. In addition, market dynamics and regulatory changes have impacted our ability to offer plan sponsors pricing that includes the use of retail "differential" or "spread", which could negatively impact our future profitability. Further, changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to patent term extensions, purchase discount and rebate arrangements with pharmaceutical manufacturers, or to formulary management or other PBM services could also reduce the discounts or rebates we receive. Our Retail Pharmacy Segment has also been impacted by the margin pressures described above.

Regulatory and business changes relating to our participation in Medicare Part D.

Since its inception in 2006, Medicare Part D has resulted in increased utilization and decreased pharmacy gross margin rates as higher margin business, such as cash and state Medicaid customers, migrated to Medicare Part D coverage. Further, as a result of Medicare Part D and as a result of the expected elimination in 2013 of the tax deductibility of the retiree drug subsidy payment received by sponsors of retiree drug plans, our PBM clients could decide to discontinue providing prescription drug benefits to their Medicare-eligible members. To the extent this occurs, the adverse effects of increasing customer migration into Medicare Part D may outweigh the benefits we realize from growth of our Medicare Part D business. In addition, if the cost and complexity of Medicare Part D

exceed management's expectations or prevent effective program implementation or administration; if changes to the regulations regarding how drug costs are reported for Medicare Part D and retiree drug subsidy purposes are implemented in a manner that impacts the profitability of our Medicare Part D business; if the government alters Medicare program requirements or reduces funding because of the higher-than-anticipated cost to taxpayers of Medicare Part D or for other reasons; if we fail to design and maintain programs that are attractive to Medicare participants; if CMS imposes sanctions or other restrictions on our Medicare Part D business as a result of audits or other regulatory actions; if we fail to successfully implement corrective action or other remedial measures sufficient to prevent or remove any applicable sanctions or other restrictions that may be imposed by CMS; if we fail to effectively integrate and operate the Medicare Part D businesses we have acquired; or if we are not successful in retaining enrollees, or winning contract renewals or new contracts under Medicare Part D's competitive bidding process, our Medicare Part D services and the ability to expand our Medicare Part D services could be impacted.

Possible changes in industry pricing benchmarks.

Implementation of the FDB and Medi-Span settlements, described in the Government Regulation section, have resulted in changes in the methodology used to calculate AWP, which is the pricing reference used for many of our PBM client contracts, pharmaceutical purchase agreements, retail network contracts, specialty payor agreements and other contracts with third party payors. Following these settlements, FDB discontinued the publishing of AWP in September 2011. Although Medi-Span continues to publish AWP, it is possible that the pharmaceutical industry may evaluate and/or develop an alternative pricing reference to replace AWP. Future changes to the use of AWP or to other published pricing benchmarks used to establish pharmaceutical pricing, including changes in the basis for calculating reimbursement by federal and state health programs and/or other payors, could impact the reimbursement we receive from Medicare and Medicaid programs, the reimbursement we receive from PBM clients and other payors and/or our ability to negotiate rebates and/or discounts with pharmaceutical manufacturers, wholesalers, PBMs and retail pharmacies. The effect of these possible changes on our business cannot be predicted at this time.

An extremely competitive business environment.

Each of the retail pharmacy business and the pharmacy services business currently operates in a highly competitive and evolving health care environment. Our competitive success is impacted by the ability of our retail pharmacy business to establish and maintain contractual relationships with PBMs and other payors on acceptable terms and by the ability of our pharmacy services business to establish and maintain contractual relationships with network pharmacies in an environment where some PBM clients are considering adopting narrow or restricted retail pharmacy networks.

As a pharmacy retailer, we compete with other drugstore chains, supermarkets, discount retailers, independent pharmacies, membership clubs, Internet companies and retail health clinics, as well as other mail order pharmacies and PBMs. In that regard, many pharmacy benefit plans have implemented plan designs that mandate or provide incentives to fill maintenance medications through mail order pharmacies. To the extent this trend continues, our retail pharmacy business could be adversely affected (although the effect of this would likely be mitigated by an increase in our own mail order business and/or an increase in participation in our Maintenance Choice program). In addition, some of these competitors may offer services and pricing terms that we may not be willing or able to offer. Competition may also come from other sources in the future.

Competitors in the PBM industry (e.g., Express Scripts, Catamaran, OptumRx and Prime Therapeutics), include large, national PBM companies, PBMs owned by large national health plans and smaller standalone PBMs. Some of these competitors may offer services and pricing terms that we may not be willing or able to offer. In addition, competition may also come from other sources in the future.

Reform of the U.S. health care system.

Congressional efforts to reform the U.S. health care system finally came to fruition in 2010 with the passage of ACA, which is resulting in significant structural changes to the health insurance system. Many of the structural changes enacted by ACA are not scheduled to be implemented until 2014, and many of the applicable regulations and sub-regulatory guidance have not yet been issued and/or finalized. Therefore, there is considerable uncertainty as to the full impact of ACA on our business. While these reforms may not affect our business directly, they affect the coverage and plan designs that are or will be provided by many of our health plan clients. As a result, they could indirectly impact many of our services and business practices. The Company cannot predict what effect, if any, the ACA changes may have on its retail pharmacy and pharmacy services businesses, and it is possible that other legislative or market-driven changes in the health care system that the Company cannot anticipate could also occur.

The failure to properly maintain our information technology systems, our information security systems and our infrastructure to support our business and to protect the privacy and security of sensitive customer and business information.

Many aspects of our operations are dependent on our information systems and the information collected, processed, stored, and handled by these systems. Throughout our operations, we receive, retain and transmit certain confidential information, including personal information that our customers and clients provide to purchase products or services, enroll in programs or services, register on our websites, interact with our personnel, or otherwise communicate with us. In addition, for these operations, we depend in part on the secure transmission of confidential information over public networks. Our information systems are subject to damage or interruption from power outages, computer and telecommunications failures, computer viruses, security breaches, vandalism, catastrophic events and human error. Although we have developed systems and processes that are designed to protect confidential information against security breaches, a compromise of our information security controls or those of businesses with whom we interact, which results in confidential information being accessed, obtained, or used by unauthorized or improper persons, could harm our reputation and expose us to regulatory actions and claims from customers and clients, financial institutions, payment card associations and other persons, any of which could adversely affect our business, financial position, and results of operations. Moreover, a security breach could require that we expend significant resources related to our information systems and infrastructure, and could distract management and other key personnel from performing their primary operational duties. If our information systems are damaged, fail to work properly or otherwise become unavailable, or if we are unable to successfully complete our planned consolidation of our PBM claims adjudication platforms, we may incur substantial costs to repair or replace them, and may experience loss of critical information, customer disruption and interruptions or delays in our ability to perform essential functions. In addition, compliance with changes in privacy and information security laws and standards may result in considerable expense due to increased investment in technology and the development of new operational processes.

Risks related to compliance with a broad and complex regulatory framework.

Our business is subject to numerous federal, state and local laws and regulations. See “Business – Government Regulation.” Changes in these regulations may require extensive system and operating changes that may be difficult to implement. Untimely compliance or noncompliance with applicable laws and regulations could adversely affect the continued operation of our business, including, but not limited to: imposition of civil or criminal penalties; suspension or disgorgement of payments from government programs; loss of required government certifications or approvals; loss of authorizations to participate in or exclusion from government reimbursement programs, such as the Medicare and Medicaid programs; or loss of registrations or licensure. The regulations to which we are subject include, but are not limited to: the laws and regulations described in the Government Regulation section; accounting standards; securities laws and regulations; tax laws and regulations; laws and regulations relating to the protection of the environment and health and safety matters, including those governing exposure to, and the management and disposal of, hazardous materials and wastes; and regulations of the FDA, the FTC, the DEA, and the Consumer Product Safety Commission, as well as state regulatory authorities, governing the sale, advertisement and promotion of products that we sell. In addition, our business interests outside of the United States are subject to the Foreign Corrupt Practices Act and other applicable domestic and international laws and regulations. We are also subject to the terms of various government agreements and mandates, including those described in the Government Regulation section. In that regard, our business, financial position and results of operations could be affected by existing and new government legislative and regulatory action, including, without limitation, any one or more of the following:

- federal and state laws and regulations governing the purchase, distribution, management, dispensing and reimbursement of prescription drugs and related services, whether at retail or mail, and applicable registration or licensing requirements;
- the effect of the expiration of patents covering brand name drugs and the introduction of generic products;
- the frequency and rate of approvals by the FDA of new brand-name and generic drugs, or of over-the-counter status for brand name drugs;
- FDA regulation affecting the retail or PBM industry;
- consumer protection laws affecting our health care services, our loyalty programs, the products we sell and/or the marketing of our goods and services;

- rules and regulations issued pursuant to HIPAA and the HITECH Act; and other federal and state laws affecting the collection, use, disclosure and transmission of health or other personal information, such as federal laws on information privacy precipitated by concerns about information collection through the Internet, state security breach laws and state laws limiting the use and disclosure of prescriber information;
- administration of Medicare Part D, including legislative changes and/or CMS rulemaking and interpretation;
- government regulation of the development, administration, review and updating of formularies and drug lists;
- federal, state and local waste management laws and regulations applicable to our business, including the management of pharmaceutical wastes and photo processing solutions, as well as the storage and transportation of hazardous materials;
- state laws and regulations establishing or changing prompt payment requirements for payments to retail pharmacies;
- impact of network access legislation, including "any willing provider" laws, on our ability to manage pharmacy networks;
- managed care reform and plan design legislation;
- insurance licensing and other insurance regulatory requirements applicable to offering Medicare Part D programs and services or other health care services; and
- direct regulation of pharmacies or PBMs by regulatory and quasi-regulatory bodies.

Risks related to litigation and other legal proceedings.

Pharmacy services and retail pharmacy are highly regulated and litigious industries. Our Company is currently subject to various litigation matters and legal proceedings. As such, we refer you to Item 3. "Legal Proceedings" for additional information.

The foregoing is not a comprehensive listing and there can be no assurance that we have correctly identified and appropriately assessed all factors affecting the business. As such, we refer you to the "Management's Discussion and Analysis of Financial Condition and Results of Operations," which includes our "Cautionary Statement Concerning Forward-Looking Statements" at the end of such section of our Annual Report to Stockholders for the year ended December 31, 2012, which section is incorporated by reference.

Item 1B. Unresolved Staff Comments

There are no unresolved SEC Staff Comments.

Item 2. Properties

We lease most of our stores under long-term leases that vary as to rental amounts, expiration dates, renewal options and other rental provisions. For additional information on the amount of our rental obligations for our leases, we refer you to the Note “Leases” in our Annual Report to Stockholders for the year ended December 31, 2012, which section is incorporated by reference herein.

As of December 31, 2012, we owned approximately 5% of our 7,458 retail stores. Net selling space for our retail drugstores increased to 73.1 million square feet as of December 31, 2012. More than one third of our store base was opened or significantly remodeled within the last five years.

We own ten distribution centers located in Alabama, California, Hawaii, New York, Rhode Island, South Carolina, Tennessee and Texas and lease nine additional distribution facilities located in Arizona, Florida, Indiana, Michigan, New Jersey, Pennsylvania, Texas and Virginia. The 19 distribution centers total approximately 11.5 million square feet as of December 31, 2012.

As of December 31, 2012, we owned one mail service pharmacy located in Texas and leased five additional mail service pharmacies located in Florida, Hawaii, Illinois and Pennsylvania. We leased call centers located in Missouri, Pennsylvania, Tennessee and Texas. As of December 31, 2012, we also had 19 onsite pharmacy stores, which we leased, 31 specialty pharmacy stores, which we leased, and 12 specialty mail order pharmacies, one of which we owned.

We own our corporate offices located in Woonsocket, Rhode Island, which totals approximately 1,000,000 square feet. In addition, we lease large corporate offices in Scottsdale, Arizona, Northbrook, Illinois and Irving, Texas.

In connection with certain business dispositions completed between 1991 and 1997, we continue to guarantee lease obligations for approximately 74 former stores. We are indemnified for these guarantee obligations by the respective purchasers. These guarantees generally remain in effect for the initial lease term and any extension thereof pursuant to a renewal option provided for in the lease prior to the time of the disposition. For additional information, we refer you to Note 13 “Commitments and Contingencies” in our Annual Report to Stockholders for the year ended December 31, 2012, which section is incorporated by reference herein.

Management believes that its 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 alternate space.

The following is a breakdown by state, District of Columbia and Puerto Rico of our retail stores, onsite pharmacy stores, specialty pharmacy stores and specialty mail order pharmacies as of December 31, 2012:

	Retail Stores	Onsite Pharmacy Stores	Specialty Pharmacy Stores	Specialty Mail Order Pharmacies	Total
Alabama	152	—	1	—	153
Arkansas	1	—	—	—	1
Arizona	136	—	1	—	137
California	846	—	5	1	852
Colorado	—	—	1	—	1
Connecticut	145	1	—	—	146
Delaware	7	—	—	—	7
District of Columbia	58	—	1	—	59
Florida	715	—	3	1	719
Georgia	315	2	1	—	318
Hawaii	51	—	1	—	52
Iowa	13	2	—	—	15
Illinois	272	1	1	1	275
Indiana	294	—	—	—	294
Kansas	32	—	—	1	33
Kentucky	62	—	—	—	62
Louisiana	106	—	—	—	106
Maine	22	—	—	—	22
Maryland	170	1	—	—	171
Massachusetts	352	—	3	1	356
Michigan	248	1	—	1	250
Minnesota	55	1	—	—	56
Mississippi	48	—	—	—	48
Missouri	61	1	1	—	63
Montana	14	—	—	—	14
Nebraska	16	—	—	—	16
Nevada	86	—	—	—	86
New Hampshire	39	—	—	—	39
New Jersey	272	3	—	1	276
New Mexico	14	—	—	—	14
New York	463	—	2	—	465
North Carolina	308	—	1	1	310
North Dakota	6	—	—	—	6
Ohio	316	2	—	—	318
Oklahoma	46	—	—	—	46
Oregon	—	—	1	—	1
Pennsylvania	401	1	1	1	404
Puerto Rico	17	—	—	1	18
Rhode Island	60	—	1	—	61
South Carolina	195	—	1	—	196
Tennessee	133	1	1	1	136
Texas	551	1	3	1	556
Vermont	4	—	—	—	4
Virginia	266	—	—	—	266
Washington	—	—	1	—	1
West Virginia	49	—	—	—	49
Wisconsin	41	1	—	—	42
	7,458	19	31	12	7,520

Item 3. Legal Proceedings

I. Legal Proceedings

1. Caremark (the term "Caremark" being used herein to generally refer to any one or more pharmacy benefit management subsidiaries of the Company, as applicable) is a defendant in a *qui tam* lawsuit initially filed by a relator on behalf of various state and federal government agencies in Texas federal court in 1999. The case was unsealed in May 2005. The case seeks monetary damages and alleges that Caremark's processing of Medicaid and certain other government claims on behalf of its clients (which allegedly resulted in underpayments from our clients to the applicable government agencies) on one of Caremark's adjudication platforms violates applicable federal or state false claims acts and fraud statutes. The United States and the States of Texas, Tennessee, Florida, Arkansas, Louisiana and California intervened in the lawsuit, but Tennessee and Florida withdrew from the lawsuit in August 2006 and May 2007, respectively. Thereafter, in 2008, the Company prevailed on several motions for partial summary judgment and, following an appellate ruling from the Fifth Circuit Court of Appeals in 2011 which affirmed in part and reversed in part these prior rulings, the claims asserted in the case against Caremark have been substantially narrowed. In December 2007, the Company received a document subpoena from the OIG within the HHS, requesting information relating to the processing of Medicaid and other government agency claims on a different adjudication platform of Caremark. The Company has been providing documents and other information in response to this request for information. The Company has been conducting discussions with the DOJ and the OIG regarding a possible settlement of these legal matters.

2. In April 2009, the State of Texas filed a purported civil enforcement action against Caremark for injunctive relief, damages and civil penalties in Travis County, Texas alleging that Caremark violated the Texas Medicaid Fraud Prevention Act and other state laws based on its processing of Texas Medicaid claims on behalf of PBM clients on one of Caremark's adjudication platforms. In September 2011, the Company prevailed on a motion for partial summary judgment against the State of Texas and narrowed the remaining claims in the lawsuit. In October 2009 and October 2010, the Company received civil investigative demands from the Office of the Attorney General of the State of Texas requesting, respectively, information produced under the OIG subpoena described above and other information related to the processing of Medicaid claims. These civil investigative demands state that the Office of the Attorney General of the State of Texas is investigating allegations currently pending under seal relating to two other adjudication platforms of Caremark. In January 2012, the parties filed joint motions with the Texas federal and state courts requesting that the lawsuits with the State of Texas be abated so that the parties can focus on completing settlement documentation relating to Caremark's processing of Texas Medicaid claims.

3. Caremark was named in a putative class action lawsuit filed in October 2003 in Alabama state court by John Lauriello, purportedly on behalf of participants in the 1999 settlement of various securities class action and derivative lawsuits against Caremark and others. Other defendants include insurance companies that provided coverage to Caremark with respect to the settled lawsuits. The Lauriello lawsuit seeks approximately $3.2 billion in compensatory damages plus other non-specified damages based on allegations that the amount of insurance coverage available for the settled lawsuits was misrepresented and suppressed. A similar lawsuit was filed in November 2003 by Frank McArthur, also in Alabama state court, naming as defendants Caremark, several insurance companies, attorneys and law firms involved in the 1999 settlement. This lawsuit was stayed as a later-filed class action, but McArthur was subsequently allowed to intervene in the Lauriello action. Following the close of class discovery, the trial court entered an Order on August 15, 2012 that granted the plaintiffs' motion to certify a class pursuant to Alabama Rule of Civil Procedure 23(b)(3) but denied their request that the class also be certified pursuant to Rule 23(b)(1). In addition, the August 15, 2012 Order appointed class representatives and class counsel. The defendants have filed a notice of appeal with the Alabama Supreme Court and the plaintiffs have filed a notice of cross-appeal. The proceedings in the trial court are stayed by statute pending a decision on the appeal and cross-appeal by the Alabama Supreme Court.

4. Various lawsuits have been filed alleging that Caremark has violated applicable antitrust laws in establishing and maintaining retail pharmacy networks for client health plans. In August 2003, Bellevue Drug Co., Robert Schreiber, Inc. d/b/a Burns Pharmacy and Rehn-Huerbinger Drug Co. d/b/a Parkway Drugs #4, together with Pharmacy Freedom Fund and the National Community Pharmacists Association filed a putative class action against Caremark in Pennsylvania federal court, seeking treble damages and injunctive relief. This case was initially sent to arbitration based on the contract terms between the pharmacies and Caremark. In October 2003, two independent pharmacies, North Jackson Pharmacy, Inc. and C&C, Inc. d/b/a Big C Discount Drugs, Inc., filed a putative class action complaint in Alabama federal court against Caremark and two PBM competitors, seeking treble damages and injunctive relief. The North Jackson Pharmacy case against two of the Caremark entities named as defendants was transferred to Illinois federal court, and the case against a separate Caremark entity was sent to arbitration based on contract terms between the pharmacies and Caremark. The Bellevue arbitration was then stayed by the parties pending developments in the North Jackson Pharmacy court case.

In August 2006, the Bellevue case and the North Jackson Pharmacy case were both transferred to Pennsylvania federal court by the Judicial Panel on Multidistrict Litigation for coordinated and consolidated proceedings with other cases before the panel, including cases against other PBMs. Caremark appealed the decision which vacated an order compelling arbitration and staying the proceedings in the Bellevue case and, following the appeal, the Court of Appeals reinstated the order compelling arbitration of the Bellevue case. Following remand, plaintiffs in the Bellevue case sought dismissal of their complaint to permit an immediate appeal of the reinstated order compelling arbitration and pursued an appeal to the Circuit Court of Appeals. In November 2012, the Circuit Court reversed the district court ruling and directed the parties to proceed in federal court. Motions for class certification in the coordinated cases within the multidistrict litigation, including the North Jackson Pharmacy case, remain pending. The consolidated action is now known as the In Re Pharmacy Benefit Managers Antitrust Litigation.

5. In November 2009, a securities class action lawsuit was filed in the United States District Court for the District of Rhode Island purportedly on behalf of purchasers of CVS Caremark Corporation stock between May 5, 2009 and November 4, 2009. The lawsuit names the Company and certain officers as defendants and includes allegations of securities fraud relating to public disclosures made by the Company concerning the PBM business and allegations of insider trading. In addition, a shareholder derivative lawsuit was filed in December 2009 in the same court against the directors and certain officers of the Company. A derivative lawsuit is a lawsuit filed by a shareholder purporting to assert claims on behalf of a corporation against directors and officers of the corporation. This lawsuit, which was stayed pending developments in the related securities class action, includes allegations of, among other things, securities fraud, insider trading and breach of fiduciary duties and further alleges that the Company was damaged by the purchase of stock at allegedly inflated prices under its share repurchase program. In January 2011, both lawsuits were transferred to the United States District Court for the District of New Hampshire. In June 2012, the court granted the Company's motion to dismiss the securities class action. The plaintiffs subsequently filed a notice of appeal of the Court's ruling on the motion to dismiss, and the appeal is pending. The derivative lawsuit will remain stayed pending the outcome of the appeal of the securities class action.

6. In March 2010, the Company learned that various State Attorneys General offices and certain other government agencies were conducting a multi-state investigation of certain of the Company's business practices similar to those being investigated at that time by the FTC. Twenty-eight states, the District of Columbia and the County of Los Angeles are known to be participating in this investigation. The prior FTC investigation, which commenced in August 2009, was officially concluded in May 2012 when the consent order entered into between the FTC and the Company became final. The Company continues to cooperate in the multi-state investigation.

7. In March 2010, the Company received a subpoena from the OIG requesting information about programs under which the Company has offered customers remuneration conditioned upon the transfer of prescriptions for drugs or medications to our pharmacies in the form of gift cards, cash, non-prescription merchandise or discounts or coupons for non-prescription merchandise. The subpoena relates to an investigation of possible false or otherwise improper claims for payment under the Medicare and Medicaid programs. The Company has been providing documents and other information in response to this request for information.

8. The Company received a subpoena from the SEC in February 2011 and has subsequently received additional subpoenas and other requests for information. The SEC's requests relate to, among other things, public disclosures made by the Company during 2009, transactions in the Company's securities by certain officers and employees of the Company during 2009 and the purchase accounting for the Longs Drug Stores acquisition. The Company has been providing documents and other information as requested by the SEC.

9. In January 2012, the United States District Court for the Eastern District of Pennsylvania unsealed a first amended *qui tam* complaint filed in August 2011 by an individual relator, who is described in the complaint as having once been employed by a firm providing pharmacy prescription benefit audit and recovery services. The complaint seeks monetary damages and alleges that Caremark's processing of Medicare claims on behalf of one of its clients violated the federal false claims act. The United States, acting through the U.S. Attorney's Office in Philadelphia, Pennsylvania, declined to intervene in the lawsuit. Caremark filed a motion to dismiss the amended complaint and the DOJ filed a Statement of Interest with regard to Caremark's motion to dismiss. In December 2012, the court denied Caremark's motion to dismiss the amended complaint.

10. In January 2012, the Company received a subpoena from OIG requesting information about its Health Savings Pass program, a prescription drug discount program for uninsured or under insured individuals, in connection with an investigation of possible false or otherwise improper claims for payment involving HHS programs. In February 2012, the Company also received a civil investigative demand from the Office of the Attorney General of the State of Texas requesting a copy of information produced under this OIG subpoena and other information related to prescription drug claims submitted by our pharmacies to Texas Medicaid for reimbursement. The Company has been providing documents and other information in response to this request for information.

11. A purported shareholder derivative action was filed on behalf of nominal defendant CVS Caremark Corporation against certain of the Company's officers and members of its Board of Directors. The action was originally filed in June 2012 and, after the court granted leave to amend the original filing, an amended complaint was filed in November 2012. The amended complaint alleges a single claim for breach of fiduciary duty relating to the Company's alleged failure to properly implement internal regulatory controls to comply with the Controlled Substances Act and the Combat Methamphetamine Epidemic Act.

12. In November 2012, the Company received a subpoena from the OIG requesting information concerning automatic refill programs used by pharmacies to refill prescriptions for customers. The Company is cooperating and will be providing documents and other information in response to this request for information.

13. Effective January 15, 2013, CMS imposed intermediate sanctions on our SilverScript Medicare Part D PDP, consisting of immediate suspension of further plan enrollment and marketing activities. The sanctions relate to our compliance with certain Medicare Part D requirements and do not affect the enrollment status of our current PDP enrollees. CMS has granted a limited waiver of these sanctions to allow our PDP to continue to enroll eligible retirees of existing employer clients into our SilverScript plans and into employer group waiver plans to fulfill our commitments to implement and provide employer group waiver plan services. This limited waiver currently extends through April 30, 2013, and CMS has advised us that it will consider further extensions of the waiver on a rolling basis. At the beginning of the 2013 Medicare Part D plan year, the Company implemented an enrollment systems conversion process and other actions to consolidate our PDP plans. These consolidation efforts have impacted the enrollment and coverage determination services we provide to PDP enrollees. We are cooperating with CMS to address the service issues resulting from our plan consolidation efforts and to develop and implement a corrective action plan to resolve and remove the sanctions. We cannot predict how long the sanctions will remain in effect or the scope of corrective action or other remedial actions that CMS may require in order for the sanctions to be removed.

The Company is also a party to other legal proceedings and inquiries arising in the normal course of its business, none of which is expected to be material to the Company. We can give no assurance, however, that our business, financial condition and results of operations will not be materially adversely affected, or that we will not be required to materially change our business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations, including the laws and regulations described in "Business — Government Regulation", as they may relate to our business, the pharmacy services, retail pharmacy or retail clinic industry or to the health care industry generally; (iii) pending or future federal or state governmental investigations of our business or the pharmacy services, retail pharmacy or retail clinic industry or of the health care industry generally; (iv) institution of government enforcement actions against us; (v) adverse developments in any pending *qui tam* lawsuit against us, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against us; or (vi) adverse developments in other pending or future legal proceedings against us or affecting the pharmacy services, retail pharmacy or retail clinic industry or the health care industry generally.

II. Environmental Matters

1. Item 103 of SEC Regulation S-K requires disclosure of certain environmental legal proceedings if management reasonably believes that the proceedings involve potential monetary sanctions of $100,000 or more. On January 24, 2013, the Company entered into Consent Orders with the State of Connecticut to resolve claims of alleged noncompliance with hazardous waste regulations by certain of the Company's stores in Connecticut. As part of this settlement, the company has agreed to pay $300,000 in civil penalties and $500,000 to fund supplemental environmental projects, and consented to injunctive provisions regarding future compliance with Connecticut waste laws.

Item 4. Mine Safety Disclosures

Not applicable.

Executive Officers of the Registrant

Executive Officers of the Registrant

The following sets forth the name, age and biographical information for each of our executive officers as of February 15, 2013. In each case the officer's term of office extends to the date of the board of directors meeting following the next annual meeting of stockholders of the Company. Previous positions and responsibilities held by each of the executive officers over the past five years are indicated below:

Lisa G. Bisaccia, age 56, Senior Vice President and Chief Human Resources Officer of CVS Caremark Corporation since January 2010; Vice President, Human Resources of CVS Pharmacy, Inc. from September 2004 through December 2009.

Troyen A. Brennan, M.D., age 58, Executive Vice President and Chief Medical Officer of CVS Caremark Corporation since November 2008; Executive Vice President and Chief Medical Officer of Aetna, Inc. from February 2006 through November 2008; President and Chief Executive Officer of Brigham and Women's Physician Hospital Organization from 1997 through February 2006; also President and Chief Executive Officer of Brigham and Women's Physicians Organization from 2000 through February 2006.

Mark S. Cosby, age 54, Executive Vice President of CVS Caremark Corporation and President of CVS/pharmacy since September 2011; President of Stores of Macy's, Inc., a retail chain, from April 2009 through August 2011; President of Macy's East from April 2007 through March 2009; Executive Vice President of Real Estate and Development of Macy's from July 2006 through March 2007.

Laird K. Daniels, age 44, Senior Vice President and Controller and Chief Accounting Officer of CVS Caremark Corporation since January 2010; Vice President of Finance and Retail Controller of CVS Pharmacy, Inc. from May 2009 through December 2009; Vice President of Finance-Corporate Budgeting and Analysis of CVS Pharmacy, Inc. from November 2006 until April 2009.

David M. Denton, age 47, Executive Vice President and Chief Financial Officer of CVS Caremark Corporation since January 2010; Senior Vice President and Controller/Chief Accounting Officer of CVS Caremark Corporation from March 2008 until December 2009; Senior Vice President, Financial Administration of CVS Caremark Corporation and CVS Pharmacy, Inc. from April 2007 to March 2008.

Helena B. Foulkes, age 48, Executive Vice President and Chief Health Care Strategy and Marketing Officer of CVS Caremark Corporation since March 2011; Executive Vice President and Chief Marketing Officer of CVS Caremark Corporation from January 2009 through February 2011; Senior Vice President of Health Services of CVS Caremark Corporation from May 2008 through January 2009, and of CVS Pharmacy, Inc. from October 2007 through January 2009.

Steven J. Gold, age 53, Senior Vice President and Chief Information Officer for CVS Caremark Corporation since July 2012; Senior Vice President and Chief Information Officer of Avaya, Inc. from May 2010 through June 2012; Executive Vice President, Chief Information Officer and Chief Technology Officer of GSI Commerce, Inc. from February 2005 through April 2010.

J. David Joyner, age 48, Executive Vice President of CVS Caremark Corporation since March 2011 and Executive Vice President of Sales and Account Services, Caremark Pharmacy Services since March 2004.

Per G.H. Lofberg, age 65, Executive Vice President of CVS Caremark Corporation; Executive Vice President of CVS Caremark Corporation and President of Caremark Pharmacy Services from January 2010 through August 2012; President and Chief Executive Officer of Generation Health, Inc., a pharmacogenomics company, from November 2008 through December 2009; President and Chief Executive Officer of Merck Capital Ventures, LLC, a venture capital investment company focused on the pharmaceutical industry, from January 2001 through July 2008.

Larry J. Merlo, age 57, President and Chief Executive Officer of CVS Caremark Corporation since March 2011; President and Chief Operating Officer of CVS Caremark Corporation from May 2010 through March 2011; President of CVS/pharmacy from January 2007 through August 2011; Executive Vice President of CVS Caremark Corporation from January 2007 through May 2010; Executive Vice President–Stores of CVS Corporation from April 2000 to January 2007; and Executive Vice President–Stores of CVS Pharmacy, Inc. from March 1998 to January 2007; also a director of CVS Caremark Corporation since May 2010.

Thomas M. Moriarty, age 49, Executive Vice President and General Counsel of CVS Caremark Corporation since October 2012; General Counsel of Celgene Corporation, a global biopharmaceutical company, from May 2012 through September 2012; General Counsel and Corporate Secretary of Medco Health Solutions, Inc., ("Medco"), a pharmacy benefit management company, from March 2008 through April 2012; also President of Global Pharmaceutical Strategies of Medco from March 2011 through April 2012; Senior Vice President, Pharmaceutical Strategies and Solutions of Medco from September 2007 through March 2011; and Senior Vice President, Business Development of Medco from August 2006 through March 2008.

Jonathan C. Roberts, age 57, Executive Vice President of CVS Caremark Corporation and President of Caremark Pharmacy Services since September 2012; Executive Vice President of CVS Caremark Corporation and Chief Operating Officer of Caremark Pharmacy Services from October 2010 through August 2011; Executive Vice President, Rx Purchasing, Pricing and Network Relations of CVS Caremark Corporation from January 2009 through October 2010; Senior Vice President and Chief Information Officer of CVS Caremark Corporation from May 2008 until January 2009, and of CVS Pharmacy, Inc. from January 2006 until January 2009.

Andrew J. Sussman, M.D., age 47, Senior Vice President and Associate Chief Medical Officer of CVS Caremark Corporation since March 2011 and President of MinuteClinic, L.L.C., the Company's retail-based health clinic subsidiary, since September 2009; Executive Vice President and Chief Operating Officer of the University of Massachusetts Memorial Medical Center, the major teaching affiliate of UMass Medical School, from May 2004 through August 2009.

PART II

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

Our common stock is listed on the New York Stock Exchange under the symbol "CVS." The table below sets forth the high and low sale prices of our common stock on the New York Stock Exchange Composite Tape and the quarterly cash dividends declared per share of common stock during the periods indicated.

		First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Fiscal Year
2012	High	$ 45.88	$ 46.93	$ 48.69	$ 49.80	$ 49.80
	Low	$ 41.01	$ 43.08	$ 43.65	$ 44.33	$ 41.01
	Cash dividends per common share	$ 0.16250	$ 0.16250	$0.16250	$ 0.16250	$0.65000
2011	High	$ 35.95	$ 39.50	$ 38.82	$ 41.35	$ 41.35
	Low	$ 32.08	$ 34.21	$ 31.30	$ 32.28	$ 31.30
	Cash dividends per common share	$ 0.12500	$ 0.12500	$0.12500	$ 0.12500	$0.50000

CVS Caremark has paid cash dividends every quarter since becoming a public company. Future dividend payments will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Company's Board of Directors. As of February 8, 2013, there were 22,251 registered shareholders according to the records maintained by our transfer agent.

On September 19, 2012, the Company's Board of Directors authorized a new share repurchase program for up to $6.0 billion of outstanding common stock (the "2012 Repurchase Program"). The share repurchase authorization, which was effective immediately, permits the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase transactions, and/or other derivative transactions. The 2012 Repurchase Program may be modified or terminated by the Board of Directors at any time.

On August 23, 2011, our Board of Directors authorized a share repurchase program for up to $4.0 billion of our outstanding common stock (the "2011 Repurchase Program"). The share repurchase authorization under the 2011 Repurchase Program, which was effective immediately, permitted the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase transactions, and/or other derivative transactions.

Pursuant to the authorization under the 2011 and 2012 Repurchase Programs, on September 19, 2012, the Company entered into a $1.2 billion fixed dollar accelerated share repurchase ("ASR") agreement with Barclays Bank PLC ("Barclays"). Upon payment of the $1.2 billion purchase price on September 20, 2012, the Company received a number of shares of its common stock equal to 50% of the $1.2 billion notional amount of the ASR agreement or approximately 12.6 million shares at a price of $47.71 per share. The Company received approximately 13.0 million shares of common stock on November 16, 2012 at an average price of $46.96 per share, representing the remaining 50% of the $1.2 billion notional amount of the ASR agreement and thereby concluding the agreement. The total of 25.6 million shares of common stock delivered to the Company by Barclays over the term of the ASR agreement were placed into treasury stock.

During the year ended December 31, 2012, the Company repurchased an aggregate of 95.0 million shares of common stock for approximately $4.3 billion under the 2011 and 2012 Repurchase Programs. As of December 31, 2012, the 2011 Repurchase Program was complete and there remained approximately $4.7 billion available for future repurchases under the 2012 Repurchase Program.

Fiscal Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs
October 1, 2012 through October 31, 2012	—	—	—	$4,998,170,756
November 1, 2012 through November 30, 2012	15,606,222	$46.07	15,606,222	$4,879,043,443
December 1, 2012 through December 31, 2012	4,490,900	$46.76	4,490,900	$4,669,070,943
	20,097,122		20,097,122	

Item 6. Selected Financial Data

The selected consolidated financial data of CVS Caremark Corporation as of and for the periods indicated in the five-year period ended December 31, 2012 have been derived from the consolidated financial statements of CVS Caremark Corporation. The selected consolidated financial data should be read in conjunction with the consolidated financial statements and the audit reports of Ernst & Young LLP, which are incorporated elsewhere herein.

In millions, except per share amounts	2012[1][5]	2011[1]	2010[1]	2009[1]	2008[1]
Statement of operations data:					
Net revenues	$ 123,133	$ 107,100	$ 95,778	$ 98,215	$ 87,005
Gross profit	22,506	20,561	20,219	20,358	18,272
Operating expenses	15,278	14,231	14,082	13,933	12,237
Operating profit	7,228	6,330	6,137	6,425	6,035
Interest expense, net	557	584	536	525	509
Loss on early extinguishment of debt	348	—	—	—	—
Income tax provision[2]	2,441	2,258	2,179	2,200	2,189
Income from continuing operations	3,882	3,488	3,422	3,700	3,337
Income (loss) from discontinued operations, net of tax [3]	(7)	(31)	2	(4)	(125)
Net income	3,875	3,457	3,424	3,696	3,212
Net loss attributable to noncontrolling interest[4]	2	4	3	—	—
Preference dividends, net of income tax benefit	—	—	—	—	(14)
Net income attributable to CVS Caremark	$ 3,877	$ 3,461	$ 3,427	$ 3,696	$ 3,198
Per common share data:					
Basic earnings per common share:					
Income from continuing operations attributable to CVS Caremark	$ 3.06	$ 2.61	$ 2.51	$ 2.58	$ 2.32
Loss from discontinued operations attributable to CVS Caremark	(0.01)	(0.02)	—	—	(0.09)
Net income attributable to CVS Caremark	$ 3.05	$ 2.59	$ 2.51	$ 2.58	$ 2.23
Diluted earnings per common share:					
Income from continuing operations attributable to CVS Caremark	$ 3.03	$ 2.59	$ 2.49	$ 2.55	$ 2.27
Loss from discontinued operations attributable to CVS Caremark	(0.01)	(0.02)	—	—	(0.09)
Net income attributable to CVS Caremark	$ 3.03	$ 2.57	$ 2.49	$ 2.55	$ 2.18
Cash dividends per common share	$ 0.650	$ 0.500	$ 0.350	$ 0.305	$ 0.258
Balance sheet and other data:					
Total assets	$ 65,912	$ 64,543	$ 62,169	$ 61,641	$ 60,960
Long-term debt	$ 9,133	$ 9,208	$ 8,652	$ 8,756	$ 8,057
Total shareholders' equity	$ 37,704	$ 38,051	$ 37,700	$ 35,768	$ 34,574
Number of stores (at end of year)	7,508	7,388	7,248	7,095	6,997

(1) On December 23, 2008, our Board of Directors approved a change in our fiscal year-end from the Saturday nearest December 31 of each year to December 31 of each year to better reflect our position in the health care, rather than the retail, industry. The fiscal year change was effective beginning with the fourth quarter of fiscal 2008. As you review our operating performance, please consider that 2012 includes 366 days, 2011, 2010 and 2009 include 365 days, and fiscal 2008 includes 368 days.

(2) Income tax provision includes the effect of the following: (i) in 2010, the recognition of $47 million of previously unrecognized tax benefits, including interest, relating to the expiration of various statutes of limitation and settlements with tax authorities, (ii) in 2009, the recognition of $167 million of previously unrecognized tax benefits, including interest, relating to the expiration of various statutes of limitation and settlements with tax authorities.

(3) As discussed in Note 4 to the consolidated financial statements, the results of the TheraCom business are presented as discontinued operations and have been excluded from continuing operations for all periods presented.

In connection with certain business dispositions completed between 1991 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Linens 'n Things which filed for bankruptcy in 2008. The Company's income (loss) from discontinued operations includes lease-related costs which the Company believes it will likely be required to satisfy pursuant to its Linens 'n Things lease guarantees.

Below is a summary of the results of discontinued operations:

	Fiscal Year				
In millions	2012	2011	2010	2009	2008
Income from operations of TheraCom	$ —	$ 18	$ 28	$ 13	$ 11
Gain on disposal of TheraCom	—	53	—	—	—
Loss on disposal of Linens 'n Things	(12)	(7)	(24)	(19)	(214)
Income tax benefit (provision)	5	(95)	(2)	2	78
Income (loss) from discontinued operations, net of tax	$ (7)	$ (31)	$ 2	$ (4)	$ (125)

(4) Represents the minority shareholders' portion of the net loss from our then-majority owned subsidiary, Generation Health, Inc., acquired in the fourth quarter of 2009. In June 2012, the Company acquired the remaining 40% interest in Generation Health, Inc. from minority shareholders and employee option holders for $26 million and $5 million, respectively, for a total of $31 million.

(5) Effective January 1, 2012, the Company changed its methods of accounting for prescription drug inventories in the Retail Pharmacy Segment. Additional details of the accounting change are discussed in Note 2 to the consolidated financial statements.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

We refer you to the "Management's Discussion and Analysis of Financial Condition and Results of Operations," which includes our "Cautionary Statement Concerning Forward-Looking Statements" at the end of such section of our Annual Report to Stockholders for the year ended December 31, 2012, which section is incorporated by reference herein.

Item 7A. Quantitative and Qualitative Disclosures about Market Risk

As of December 31, 2012, the Company had no derivative financial instruments or derivative commodity instruments in place and believes that its exposure to market risk associated with other financial instruments, principally interest rate risk inherent in its debt portfolio, is not material.

Item 8. Financial Statements and Supplementary Data

We refer you to the "Consolidated Statements of Income," "Consolidated Balance Sheets," "Consolidated Statements of Shareholders' Equity," "Consolidated Statements of Cash Flows," and "Notes to Consolidated Financial Statements," and "Report of Independent Registered Public Accounting Firm" of our Annual Report to Stockholders for the fiscal year ended December 31, 2012, which sections are incorporated by reference herein.

Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure

None.

Item 9A. Controls and Procedures

Evaluation of disclosure controls and procedures: The Company's Chief Executive Officer and Chief Financial Officer, after evaluating the effectiveness of the design and operation of the Company's disclosure controls and procedures (as defined in Exchange Act Rules 13a-15 (f) and 15d-15(f)) as of December 31, 2012, have concluded that as of such date the Company's disclosure controls and procedures were adequate and effective and designed to ensure that material information relating to the Company and its subsidiaries would be made known to such officers on a timely basis.

Internal control over financial reporting: We refer you to "Management's Report on Internal Control Over Financial Reporting" and "Report of Independent Registered Public Accounting Firm" of our Annual Report to Stockholders for the fiscal year ended December 31, 2012, which are incorporated by reference herein, for Management's report on the Registrant's internal control over financial reporting and the Independent Registered Public Accounting Firm's report with respect to the effectiveness of internal control over financial reporting.

Changes in internal control over financial reporting: There have been no changes in our internal controls over financial reporting identified in connection with the evaluation required by paragraph (d) of Rule 13a-15 or Rule 15d-15 that occurred during the fourth quarter ended December 31, 2012 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information

No events have occurred during the fourth quarter that would require disclosure under this item.

PART III

Item 10. Directors, Executive Officers and Corporate Governance

We refer you to our Proxy Statement for the 2013 Annual Meeting of Stockholders under the captions “Committees of the Board,” “Code of Conduct,” “Director Nominations,” “Audit Committee Report,” “Biographies of our Board Nominees,” and “Section 16(a) Beneficial Ownership Reporting Compliance,” which sections are incorporated by reference herein. Biographical information on our executive officers is contained in Part I of this Annual Report on Form 10-K.

Item 11. Executive Compensation

We refer you to our Proxy Statement for the 2013 Annual Meeting of Stockholders under the captions “Executive Compensation and Related Matters,” including “Compensation Discussion & Analysis” and “Management Planning and Development Committee Report,” which sections are incorporated by reference herein.

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

We refer you to our Proxy Statement for the 2013 Annual Meeting of Stockholders under the captions “Share Ownership of Directors and Certain Executive Officers,” and “Share Ownership of Principal Stockholders” which sections are incorporated by reference herein, for information concerning security ownership of certain beneficial owners and management and related stockholder matters.

The following table summarizes information about the Company’s common stock that may be issued upon the exercise of options, warrants and rights under all of our equity compensation plans as of December 31, 2012.

	Number of securities to be issued upon exercise of outstanding options, warrants and rights[1]	Weighted average exercise price of outstanding options, warrants and rights	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in first column) [1]
Equity compensation plans approved by stockholders [2]	40,929	$ 36.57	47,885
Equity compensation plans not approved by stockholders	—	—	—
Total	40,929	$ 36.57	47,885

(1) Shares in thousands.

(2) The number of shares available for delivery under the 2010 Incentive Compensation Plan (the “2010 ICP”) is subject to adjustment in the event shares subject to awards under a predecessor plan are cancelled or forfeited; in such event the shares shall again be available for grants or awards. See Note 14, “Stock Incentive Plans” to the consolidated financial statements for amendments to the 2010 ICP.

Item 13. Certain Relationships and Related Transactions and Director Independence

We refer you to our Proxy Statement for the 2013 Annual Meeting of Stockholders under the caption “Independence Determinations for Directors” and “Certain Transactions with Directors and Officers,” which sections are incorporated by reference herein.

Item 14. Principal Accountant Fees and Services

We refer you to our Proxy Statement for the 2013 Annual Meeting of Stockholders under the caption “Item 2: Ratification of Appointment of Independent Registered Public Accounting Firm,” which section is incorporated by reference herein.

PART IV

Item 15. Exhibits and Financial Statement Schedules

A. Documents filed as part of this report:

1. Financial Statements:

The following financial statements are incorporated by reference from our Annual Report to Stockholders for the fiscal year ended December 31, 2012, as provided in Item 8 hereof:

2. Financial Statement Schedules

All financial statement schedules are omitted because they are not applicable, not required under the instructions, or the information is included in the consolidated financial statements or related notes.

B. Exhibits

Exhibits marked with an asterisk (*) are hereby incorporated by reference to exhibits or appendices previously filed by the Registrant as indicated in brackets following the description of the exhibit.

Exhibit	Description
2.1*	Agreement and Plan of Merger dated as of November 1, 2006 among, the Registrant, Caremark Rx, Inc. and Twain MergerSub Corp. [incorporated by reference to Exhibit 2.1 to the Registrant's Registration Statement No. 333-139470 on Form S-4 filed December 19, 2006].
2.2*	Amendment No. 1 dated as of January 16, 2007 to the Agreement and Plan of Merger dated as of November 1, 2006 among the Registrant, Caremark Rx, Inc. and Twain Merger Sub Corp. [incorporated by reference to Exhibit 2.2 to the Registrant's Registration Statement No. 333-139470 on Form S-4/A filed January 16, 2007].
2.3*	Waiver Agreement dated as of January 16, 2007 between the Registrant and Caremark Rx, Inc. with respect to the Agreement and Plan Merger dated as of November 1, 2006 by and between Registrant and Caremark Rx, Inc [incorporated by reference to Exhibit 2.3 to the Registrant's Registration Statement No. 333-139470 on Form S-4/A filed January 16, 2007].
2.4*	Amendment to Waiver Agreement, dated as of February 12, 2007, between Registrant and Caremark Rx, Inc. [incorporated by reference to Exhibit 99.2 to the Registrant's Current Report on Form 8-K dated February 13, 2007 (Commission File No. 001-01011)].
2.5*	Amendment to Waiver Agreement, dated as of March 8, 2007, between Registrant and Caremark Rx, Inc. [incorporated by reference to Exhibit 99.2 to the Registrants' Current Report on Form 8-K dated March 8, 2007 (Commission File No. 001-01011)].
2.6*	Agreement and Plan of Merger dated as of August 12, 2008 among, the Registrant, Longs Drug Stores Corporation and Blue MergerSub Corp. [incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K dated August 13, 2008 (Commission File No. 001-01011)].
3.1*	Amended and Restated Certificate of Incorporation of the Registrant [incorporated by reference to Exhibit 3.1 of CVS Corporation's Annual Report on Form 10-K for the fiscal year ended December 31, 1996 (Commission File No. 001-01011)].

3.1A*	Certificate of Amendment to the Amended and Restated Certificate of Incorporation, effective May 13, 1998 [incorporated by reference to Exhibit 4.1A to Registrant's Registration Statement No. 333-52055 on Form S-3/A dated May 18, 1998].
3.1B*	Certificate of Amendment to the Amended and Restated Certificate of Incorporation [incorporated by reference to Exhibit 3.1 to Registrant's Current Report on Form 8-K dated March 22, 2007 (Commission File No. 001-01011)].
3.1C*	Certificate of Merger dated May 9, 2007 [incorporated by reference to Exhibit 3.1C to Registrant's Quarterly Report on Form 10-Q dated November 1, 2007 (Commission File No. 001-01011)].
3.1D*	Certificate of Amendment to the Amended and Restated Certificate of Incorporation [incorporated by reference to Exhibit 3.1 to Registrant's Current Report on Form 8-K dated May 13, 2010 (Commission File No. 001-01011)].
3.1E*	Certificate of Amendment to the Amended and Restated Certificate of Incorporation [incorporated by reference to Exhibit 3.1 to the Registrant's Current Report On Form 8-K dated May 10, 2012 (Commission File No. 001-01011)].
3.2*	By-laws of the Registrant, as amended and restated [incorporated by reference to Exhibit 3.2 to the Registrant's Current Report on Form 8-K dated May 10, 2012 (Commission File No. 001-01011)].
4	Pursuant to Regulation S-K, Item 601(b)(4)(iii)(A), no instrument which defines the rights of holders of long-term debt of the Registrant and its subsidiaries is filed with this report. The Registrant hereby agrees to furnish a copy of any such instrument to the Securities and Exchange Commission upon request.
4.1*	Specimen common stock certificate [incorporated by reference to Exhibit 4.1 to the Registration Statement of the Registrant on Form 8-B dated November 4, 1996 (Commission File No. 001-01011)].
4.2*	Specimen First Supplemental Indenture between Registrant and The Bank of New York Trust Company, N. A., a national banking association [incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K dated May 22, 2007 (Commission File No. 001-01011)].
4.3*	Specimen ECAPS℠ [incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K dated May 22, 2007 (Commission File No. 001-01011)].
10.1*	Stock Purchase Agreement dated as of October 14, 1995 between The TJX Companies, Inc. and Melville Corporation, as amended November 17, 1995 [incorporated by reference to Exhibits 2.1 and 2.2 to Melville's Current Report on Form 8-K dated December 4, 1995 (Commission File No. 001-01011)].
10.2*	Stock Purchase Agreement dated as of March 25, 1996 between Melville Corporation and Consolidated Stores Corporation, as amended May 3, 1996 [incorporated by reference to Exhibits 2.1 and 2.2 to Melville's Current Report on Form 8-K dated May 5, 1996 (Commission File No. 001-01011)].
10.3*	Distribution Agreement dated as of September 24, 1996 among Melville Corporation, Footstar, Inc. and Footstar Center, Inc. [incorporated by reference to Exhibit 99.1 to Melville's Current Report on Form 8-K dated October 28, 1996 (Commission File No. 001-01011)].
10.4*	Tax Disaffiliation Agreement dated as of September 24, 1996 among Melville Corporation, Footstar, Inc. and certain subsidiaries named therein [incorporated by reference to Exhibit 99.2 to Melville's Current Report on Form 8-K dated October 28, 1996 (Commission File No. 001-01011)].
10.5*	Stockholder Agreement dated as of December 2, 1996 between the Registrant, Nashua Hollis CVS, Inc. and Linens 'n Things, Inc. [incorporated by reference to Exhibit 10(i)(6) to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 1997 (Commission File No. 001-01011)].

10.6*	Tax Disaffiliation Agreement dated as of December 2, 1996 between the Registrant and Linens 'n Things, Inc. and certain of their respective affiliates [incorporated by reference to Exhibit 10(i)(7) to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 1997 (Commission File No. 001-01011)].
10.7*	Supplemental Retirement Plan for Select Senior Management of CVS Caremark Corporation I as amended and restated in December 2008 [incorporated by reference to Exhibit 10.6 to the Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 (Commission File No. 001-01011)].
10.8*	CVS Corporation 1996 Directors Stock Plan, as amended and restated November 5, 2002 [incorporated by reference to Exhibit 10.18 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 28, 2002 (Commission File No. 001-01011)].
10.9*	CVS Caremark Deferred Stock Compensation Plan, as amended and restated [incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 (Commission File No. 001-01011)].
10.10*	1997 Incentive Compensation Plan as amended through December 2008 [incorporated by reference to Exhibit 10.8 to the Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 (Commission File No. 001-01011)].
10.11*	Caremark Rx, Inc. 2004 Incentive Stock Plan [incorporated by reference to Exhibit 99.2 of the Registrant's Registration Statement No. 333-141481 on Form S-8 filed March 22, 2007].
10.12*	2007 Employee Stock Purchase Plan [incorporated by reference to Exhibit D of the Registrant's Definitive Proxy Statement filed April 4, 2007 (Commission File No. 001-01011)].
10.13*	Amended and Restated Employment Agreement dated as of December 22, 2008 between the Registrant and the Registrant's President and Chief Executive Officer [incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2008 (Commission File No. 001-01011)].
10.14*	Universal 409A Definition Document dated December 31, 2008 [incorporated by reference to Exhibit 10.7 to the Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 (Commission File No. 001-01011)].
10.15*	Three Year Credit Agreement dated as of May 27, 2010 by and among the Registrant, the lenders party hereto, Barclays Capital and JP Morgan Chase Bank, N.A., as Co-Syndication Agents, Bank of America, N.A. and Wells Fargo Bank, N.A., as Co-Documentation Agents, and the Bank of New York Mellon, as Administrative Agent [incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2010 (Commission File No. 001-01011)].
10.16*	Employment Agreement between the Registrant and the Registrant's Executive Vice President and President of Caremark Pharmacy Services effective as of January 1, 2010 [incorporated by reference to Exhibit 10.34 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2010 (Commission File No. 001-01011)].

10.17*	Change in Control Agreement between the Registrant and the Registrant's Executive Vice President and former President of Caremark Pharmacy Services effective as of January 1, 2010 [incorporated by reference to Exhibit 10.34 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2010 (Commission File No. 001-01011)].
10.18*	Long Term Incentive Plan – former President, Pharmacy Benefit Management [incorporated by reference to Exhibit 10.36 of the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2010 (Commission File No. 001-01011)].
10.19*	Change in Control Agreement dated December 22, 2008 between the Registrant and the Registrant's Executive Vice President and Chief Financial Officer [incorporated by reference to Exhibit 10.39 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2010 (Commission File No. 001-01011)].
10.20*	Four Year Credit Agreement dated as of May 12, 2011 by and among the Registrant, the lenders party thereto, Barclays Capital and JP Morgan Chase Bank, N.A., as Co-Syndication Agents, Bank of America, N.A. and Wells Fargo Bank, N.A., as Co-Documentation Agents, and the Bank of New York Mellon, as Administrative Agent [incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2011 (Commission File No. 001-01011)].
10.21*	Executive Severance Policy effective March 31, 2011 [incorporated by reference to Exhibit 10.39 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2011 (Commission File No. 001-01011)].
10.22*	Letter Agreement dated August 5, 2011 between the Registrant and the Registrant's Executive Vice President and President – CVS/pharmacy [incorporated by reference to Exhibit 10.41 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2011 (Commission File No. 001-01011)].
10.23*	Change in Control Agreement dated September 1, 2011 between the Registrant and the Registrant's Executive Vice President and President – CVS/pharmacy [incorporated by reference to Exhibit 10.42 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2011 (Commission File No. 001-01011)].
10.24*	Amendment No. 1, dated as of November 22, 2011, to the Five Year Credit Agreement dated as of March 12, 2007 by and among the Registrant, the Lenders party thereto, the Co-Syndication Agents and Co-Documentation Agents named therein, and The Bank of New York Mellon, as Administrative Agent [incorporated by reference to Exhibit 10.43 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2011 (Commission File No. 001-01011)].
10.25*	Amendment No. 1, dated as of November 22, 2011, to the Three Year Credit Agreement dated as of May 27, 2010 by and among the Registrant, the Lenders party thereto, the Co-Syndication Agents and Co-Documentation Agents named therein, and The Bank of New York Mellon, as Administrative Agent [incorporated by reference to Exhibit 10.44 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2011 (Commission File No. 001-01011)].
10.26*	Amendment No. 1, dated as of November 22, 2011, to the Credit Agreement dated as of May 12, 2011 by and among the Registrant, the Lenders party thereto, the Co-Syndication Agents and Co-Documentation Agents named therein, and The Bank of New York Mellon, as Administrative Agent [incorporated by reference to Exhibit 10.45 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2011 (Commission File No. 001-01011)].
10.27*	Amendment dated March 29, 2012 to the Employment Agreement between the Registrant and the Registrant's Executive Vice President and President of CVS Caremark Pharmacy Services [incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K dated March 29, 2012 (Commission File No. 001-01011)].
10.28*	Form of Restricted Stock Unit Agreement between the Registrant and the Registrant's President and Chief Executive Officer [incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2012 (Commission File No. 001-01011)].

10.29*	Five Year Credit Agreement dated as of February 17, 2012, by and among the Registrant, the lenders party thereto, Barclays Capital and JPMorgan Chase Bank, N.A., as Co-Syndication Agents, Bank of America, N.A. and Wells Fargo Bank, N.A., as Co-Documentation Agents, and The Bank of New York Mellon, as Administrative Agent [incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2012 (Commission File No. 001-01011)].
10.30	2010 Incentive Compensation Plan, as amended through January 15, 2013.
10.31	Amendment dated December 21, 2012 to the Amended and Restated Employment Agreement dated as of December 22, 2008 between the Registrant and the Registrant's President and Chief Executive Officer.
10.32	Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and the Registrant's Executive Vice President and Chief Financial Officer.
10.33	Change in Control Agreement dated December 22, 2008 between the Registrant and the Registrant's Executive Vice President and President of CVS Caremark Pharmacy Services.
10.34	Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and the Registrant's Executive Vice President and President of CVS Caremark Pharmacy Services.
10.35	The Registrant's Partnership Equity Program (Revised December 2012).
10.36	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement. (Pre-Tax).
10.37	Form of Partnership Equity Program Participant Purchased Shares, Company Matching RSUs and Company Matching Option Agreement. (Post-Tax).
10.38	Form of Non-Qualified Stock Option Agreement between the Registrant and the selected employees of the Registrant.
10.39	Form of Restricted Stock Unit Agreement – Annual Grant -- between the Registrant and the selected employees of the Registrant.
10.40	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and the selected employees of the Registrant.
10.41	The Registrant's Long-Term Incentive Plan.
10.42	The Registrant's 2012 Management Incentive Plan.
10.43	The Registrant's Performance-Based Restricted Stock Unit Plan.
13	Portions of the 2012 Annual Report to Stockholders of CVS Caremark Corporation, which are specifically designated in this Form 10-K as being incorporated by reference.
21	Subsidiaries of the Registrant.
23	Consent of Ernst & Young LLP.
31.1	Certification by the Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification by the Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1	Certification by the Chief Executive Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification by the Chief Financial Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101	The following materials from the CVS Caremark Corporation Annual Report on Form 10-K for the year ended December 31, 2012 formatted in Extensible Business Reporting Language (XBRL): (i) the Consolidated Statements of Income, (ii) the Consolidated Balance Sheets, (iii) the Consolidated Statements of Cash Flows and (iv) related notes.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this Annual Report on Form 10-K to be signed on its behalf by the undersigned, thereunto duly authorized.

CVS CAREMARK CORPORATION

Date: February 15, 2013

By: /s/ DAVID M. DENTON
David M. Denton
Executive Vice President and Chief Financial Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title(s)	Date
/s/ C. DAVID BROWN II **C. David Brown II**	Director	February 15, 2013
/s/ LAIRD K. DANIELS **Laird K. Daniels**	Senior Vice President – Finance and Controller (Principal Accounting Officer)	February 15, 2013
/s/ DAVID M. DENTON **David M. Denton**	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 15, 2013
/s/ DAVID W. DORMAN **David W. Dorman**	Chairman of the Board and Director	February 15, 2013
/s/ ANNE M. FINUCANE **Anne M. Finucane**	Director	February 15, 2013
/s/ KRISTEN GIBNEY- WILLIAMS **Kristen Gibney Williams**	Director	February 15, 2013
/s/ MARIAN L. HEARD **Marian L. Heard**	Director	February 15, 2013
/s/ LARRY J. MERLO **Larry J. Merlo**	President and Chief Executive Officer (Principal Executive Officer) and Director	February 15, 2013

Signature	Title(s)	Date
/s/ JEAN-PIERRE MILLON **Jean-Pierre Millon**	Director	February 15, 2013
/s/ C.A. LANCE PICCOLO **C.A. Lance Piccolo**	Director	February 15, 2013
/s/ RICHARD J. SWIFT **Richard J. Swift**	Director	February 15, 2013
/s/ TONY L. WHITE **Tony L. White**	Director	February 15, 2013

Exhibit 13

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

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

Overview of Our Business

CVS Caremark Corporation ("CVS Caremark", the "Company", "we" or "us"), together with its subsidiaries, is the largest integrated pharmacy health care provider in the United States. We are uniquely positioned to deliver significant benefits to health plan sponsors through effective cost management solutions and innovative programs that engage plan members and promote healthier and more cost-effective behaviors. Our integrated pharmacy services model enhances our ability to offer plan members and consumers expanded choice, greater access and more personalized services to help them on their path to better health. We effectively manage pharmaceutical costs and improve health care outcomes through our pharmacy benefit management ("PBM"), mail order and specialty pharmacy division, CVS Caremark® Pharmacy Services ("Caremark"); our more than 7,400 CVS/pharmacy® retail stores; our retail-based health clinic subsidiary, MinuteClinic®; and our online retail pharmacy, CVS.com®.

We currently have three reportable segments: Pharmacy Services, Retail Pharmacy and Corporate.

Overview of Our Pharmacy Services Segment

Our Pharmacy Services business provides a full range of PBM services, including mail order and specialty pharmacy services, plan design and administration, formulary management, discounted drug purchase arrangements, Medicare Part D services, retail pharmacy network management services, prescription management systems, clinical services and disease management services.

Our clients are primarily employers, insurance companies, unions, government employee groups, managed care organizations and other sponsors of health benefit plans and individuals throughout the United States.

As a pharmacy benefits manager, we manage the dispensing of pharmaceuticals through our mail order pharmacies and national network of approximately 67,000 retail pharmacies (which include our CVS/pharmacy stores) to eligible members in the benefit plans maintained by our clients and utilize our information systems to perform, among other things, safety checks, drug interaction screenings and brand to generic substitutions.

Our specialty pharmacies support individuals that require complex and expensive drug therapies. Our specialty pharmacy business includes mail order and retail specialty pharmacies that operate under the CVS Caremark® and CarePlus CVS/pharmacy® names. Substantially all of our mail service specialty pharmacies have been accredited by The Joint Commission, which is an independent, not-for-profit organization that accredits and certifies health care organizations and programs in the United States.

We also provide health management programs, which include integrated disease management for 17 conditions, through our Accordant® health management offering. The majority of these integrated programs are accredited by the National Committee for Quality Assurance.

In addition, through our SilverScript Insurance Company ("SilverScript") and Pennsylvania Life Insurance Company ("Pennsylvania Life") subsidiaries, we are a national provider of drug benefits to eligible beneficiaries under the Federal Government's Medicare Part D program. We currently provide Medicare Part D plan benefits to approximately 3.9 million beneficiaries through the above mentioned insurance companies.

Our Pharmacy Services Segment generates net revenues primarily by contracting with clients to provide prescription drugs to plan members. Prescription drugs are dispensed by our mail order pharmacies, specialty pharmacies and national network of retail pharmacies. Net revenues are also generated by providing additional services to clients, including administrative services such as claims processing and formulary management, as well as health care-related services such as disease management.

The Pharmacy Services Segment operates under the CVS Caremark® Pharmacy Services, Caremark®, CVS Caremark®, CarePlus CVS/pharmacy®, RxAmerica® and Accordant® names. As of December 31, 2012, the Pharmacy Services Segment operated 31 retail specialty pharmacy stores, 12 specialty mail order pharmacies and five mail service pharmacies located in 22 states, Puerto Rico and the District of Columbia.

Overview of Our Retail Pharmacy Segment

Our Retail Pharmacy Segment sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products and cosmetics, photo finishing, seasonal merchandise, greeting cards and convenience foods through our CVS/pharmacy® and Longs Drugs® retail stores and online through CVS.com®. Our Retail Pharmacy Segment derives the majority of its revenues through the sale of prescription drugs, which are dispensed by our more than 26,000 retail pharmacists. The role of our retail pharmacists is shifting from primarily dispensing prescriptions to also providing services, including flu vaccinations as well as face-to-face patient counseling with respect to adherence to drug therapies, closing gaps in care, and more cost-effective drug therapies. Our integrated pharmacy services model enables us to enhance access to care while helping to lower overall health care costs and improve health outcomes.

Our Retail Pharmacy Segment also provides health care services through our MinuteClinic® health care clinics. MinuteClinics are staffed by nurse practitioners and physician assistants who utilize nationally recognized protocols to diagnose and treat minor health conditions, perform health screenings, monitor chronic conditions, and deliver vaccinations. We believe our clinics provide quality services that are quick, affordable and convenient.

Our proprietary loyalty card program, ExtraCare®, has approximately 70 million active cardholders, making it one of the largest and most successful retail loyalty card programs in the country.

As of December 31, 2012, our Retail Pharmacy Segment included 7,458 retail drugstores (of which 7,402 operated a pharmacy) located in 42 states, the District of Columbia, and Puerto Rico operating primarily under the CVS/pharmacy® or Longs Drugs® names, 19 onsite pharmacies and 640 retail health care clinics operating under the MinuteClinic® name (of which 633 were located in CVS/pharmacy stores), and our online retail website, CVS.com®.

Overview of Our Corporate Segment

The Corporate Segment provides management and administrative services to support the Company. The Corporate Segment consists of certain aspects of our executive management, corporate relations, legal, compliance, human resources, corporate information technology and finance departments.

Results of Operations

Summary of our Consolidated Financial Results

In millions, except per common share amounts	Year Ended December 31, 2012	2011	2010
Net revenues	$ 123,133	$107,100	$ 95,778
Gross profit	22,506	20,561	20,219
Operating expenses	15,278	14,231	14,082
Operating profit	7,228	6,330	6,137
Interest expense, net	557	584	536
Loss on early extinguishment of debt	348	—	—
Income before income tax provision	6,323	5,746	5,601
Income tax provision	2,441	2,258	2,179
Income from continuing operations	3,882	3,488	3,422
Income (loss) from discontinued operations, net of tax	(7)	(31)	2
Net income	3,875	3,457	3,424
Net loss attributable to noncontrolling interest	2	4	3
Net income attributable to CVS Caremark	$ 3,877	$ 3,461	$ 3,427
Diluted earnings per common share:			
Income from continuing operations attributable to CVS Caremark	$ 3.03	$ 2.59	$ 2.49
Loss from discontinued operations attributable to CVS Caremark	(0.01)	(0.02)	—
Net income attributable to CVS Caremark	$ 3.03	$ 2.57	$ 2.49

Net revenues increased $16.0 billion in 2012 compared to 2011, and increased $11.3 billion in 2011 compared to 2010. As you review our performance in this area, we believe you should consider the following important information:

- During 2012, net revenues in our Pharmacy Services Segment increased 24.7% and net revenues in our Retail Pharmacy Segment increased 6.8% compared to the prior year.
- During 2011, net revenues in our Pharmacy Services Segment increased by 24.9% and net revenues in our Retail Pharmacy Segment increased 3.9% compared to the prior year.
- The increase in our generic dispensing rates in both of our operating segments continued to have an adverse effect on net revenue in 2012 as compared to 2011, as well as in 2011 as compared to 2010.

Please see the Segment Analysis later in this document for additional information about our net revenues.

Gross profit increased $1.9 billion, or 9.5% in 2012, to $22.5 billion, or 18.3% of net revenues, as compared to $20.6 billion, or 19.2% of net revenues in 2011. Gross profit increased $342 million, or 1.7% in 2011, to $20.6 billion, or 19.2% of net revenues, as compared to $20.2 billion, or 21.1% of net revenues in 2010.

- During 2012, gross profit in our Pharmacy Services Segment and Retail Pharmacy Segment increased by 16.1% and 9.4%, respectively, compared to the prior year. For the year ended December 31, 2012, gross profit as a percent of net revenues in our Pharmacy Services Segment and Retail Pharmacy Segment was 5.2% and 30.0%, respectively.
- During 2011, gross profit in our Retail Pharmacy Segment increased by 2.5% which was partially offset by declines in our Pharmacy Services Segment of 1.1%, compared to the prior year. For the year ended December 31, 2011, gross profit as a percent of net revenues in our Pharmacy Services Segment and Retail Pharmacy Segment was 5.6% and 29.3%, respectively.
- The increased weighting toward the Pharmacy Services Segment, which has a lower gross margin than the Retail Pharmacy Segment, is resulting in a continued decline in consolidated gross profit as a percent of net revenues. In addition, gross profit has been negatively impacted by the efforts of managed care organizations, pharmacy benefit managers and governmental and other third-party payors to reduce their prescription drug costs.
- In addition, for the three years 2010 through 2012, our gross profit continued to benefit from the increased utilization of generic drugs (which normally yield a higher gross profit rate than equivalent brand name drugs) in both the Pharmacy Services and Retail Pharmacy segments.

Please see the Segment Analysis later in this document for additional information about our gross profit.

Operating expenses increased $1.0 billion, or 7.4% in the year ended December 31, 2012, as compared to the prior year. Operating expenses as a percent of net revenues improved approximately 90 basis points to 12.4% in the year ended December 31, 2012. The increase in operating expenses in the year ended December 31, 2012 was primarily due to incremental store operating costs associated with a higher store count as compared to the prior year period, as well as the expansion of our Medicare Part D business. The improvement in operating expenses as a percent of net revenues is primarily due to expense leverage from net revenue growth and expense control initiatives.

Operating expenses increased $149 million in the year ended December 31, 2011 as compared to the prior year. Operating expenses as a percent of net revenues increased approximately 140 basis points to 13.3% in the year ended December 31, 2011. The increase in operating expenses in the year ended December 31, 2011 was primarily due to incremental store operating costs associated with a higher store count as compared to the prior year period, as well as costs associated with changes designed to streamline our Pharmacy Services Segment and expenses associated with the acquisition and integration of the Medicare prescription drug business of Universal Medicare Corp. (the "UAM Medicare Part D Business").

Please see the Segment Analysis later in this document for additional information about operating expenses.

Interest expense, net consisted of the following:

In millions	2012	2011	2010
Interest expense	$561	$588	$539
Interest income	(4)	(4)	(3)
Interest expense, net	$557	$584	$536

Net interest expense decreased $27 million during the year ended December 31, 2012, which resulted from a reduction in our average outstanding short-term and long-term debt. During 2011, net interest expense increased by $48 million, to $584 million compared to 2010, due to a higher average interest rate during the period as we shifted from short-term debt to long-term debt.

Income tax provision - Our effective income tax rate was 38.6%, 39.3% and 38.9% in 2012, 2011 and 2010, respectively. The lower effective income tax in 2012 versus 2011 primarily relates to permanent items, some of which are non-recurring in nature. The higher effective income tax in 2011 versus 2010 primarily relates to changes in the recognition of previously unrecognized tax benefits relating to the expiration of various statutes of limitation and settlements with tax authorities in 2010. In 2010, we recognized $47 million of income tax benefits related to the expiration of various statutes of limitation and settlements with tax authorities.

Income from continuing operations increased $394 million or 11.3% to $3.9 billion in 2012. Income from continuing operations increased $66 million or 1.9% to $3.5 billion in 2011 as compared to $3.4 billion in 2010. The 2012 increase in income from continuing operations was primarily related to increases in generic dispensing rates and growth of our Medicare Part D business in our Pharmacy Services Segment, as well as increased sales in the Retail Pharmacy Segment resulting from share gains in our underlying business and the contractual impasse between Express Scripts and Walgreens, our principal PBM and retail pharmacy competitors, respectively. Walgreens exited from the Express Scripts network as of January 1, 2012. Subsequently, Express Scripts and Walgreens entered into a new pharmacy network agreement that became effective on September 15, 2012.

Income (loss) from discontinued operations

In connection with certain business dispositions completed between 1991 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Linens 'n Things which filed for bankruptcy in 2008. The Company's income (loss) from discontinued operations includes lease-related costs which the Company believes it will likely be required to satisfy pursuant to its Linens 'n Things lease guarantees.

We incurred a loss from discontinued operations of $7 million in 2012, a loss from discontinued operations of $31 million in 2011 and income from discontinued operations of $2 million in 2010. The loss from discontinued operations in 2012 was primarily due to lease-related costs related to Linens 'n Things lease guarantees. The loss from discontinued operations in 2011 was primarily due to the disposition of our TheraCom subsidiary. We recognized a $53 million pre-tax gain and a $37 million after-tax loss on the sale of TheraCom. The after-tax loss was caused by the income tax treatment of TheraCom's nondeductible goodwill. Income from discontinued operations (net of tax) was $2 million in 2010 due to $28 million in income from operations of TheraCom offset by $24 million in costs associated with our Linens 'n Things lease guarantees and a $2 million tax provision.

See Note 4 "Discontinued Operations" to the consolidated financial statements for additional information about discontinued operations and Note 13 "Commitments and Contingencies" for additional information about our lease guarantees.

Net loss attributable to noncontrolling interest represents the minority shareholders' portion of the net loss from our majority owned subsidiary, Generation Health, Inc. We acquired the remaining 40% interest of Generation Health, Inc. on June 29, 2012. The net loss attributable to noncontrolling interest for the years ended December 31, 2012, 2011 and 2010 was $2 million, $4 million and $3 million, respectively.

Net income attributable to CVS Caremark increased $416 million or 12.0% to $3.9 billion (or $3.03 per diluted share) in 2012. This compares to $3.5 billion (or $2.57 per diluted share) in 2011 and $3.4 billion (or $2.49 per diluted share) in 2010. As noted above, the 2012 increase in net income attributable to CVS Caremark was primarily related to new 2012 client starts and growth of our Medicare Part D business in our Pharmacy Services Segment, as well as increased sales in the Retail Pharmacy Segment resulting from share gains in our underlying business and the contractual impasse between Express Scripts and Walgreens. The increase in net income attributable to CVS Caremark per diluted share was also driven by increased share repurchase activity in 2012 and 2011.

Segment Analysis

We evaluate the performance of our Pharmacy Services and Retail Pharmacy segments based on net revenues, gross profit and operating profit before the effect of certain intersegment activities and charges. The Company evaluates the performance of its Corporate Segment based on operating expenses before the effect of discontinued operations and certain intersegment activities and charges. The following is a reconciliation of the Company's business segments to the consolidated financial statements:

In millions	Pharmacy Services Segment [1][2]	Retail Pharmacy Segment [2]	Corporate Segment	Intersegment Eliminations [2]	Consolidated Totals
2012:					
Net revenues	$73,444	$63,654	$ —	$ (13,965)	$ 123,133
Gross profit	3,808	19,109	—	(411)	22,506
Operating profit	2,679	5,654	(694)	(411)	7,228
2011:					
Net revenues	$ 58,874	$ 59,599	$ —	$ (11,373)	$ 107,100
Gross profit	3,279	17,468	—	(186)	20,561
Operating profit	2,220	4,912	(616)	(186)	6,330
2010:					
Net revenues	$ 47,145	$ 57,345	$ —	$ (8,712)	$ 95,778
Gross profit	3,315	17,039	—	(135)	20,219
Operating profit	2,361	4,537	(626)	(135)	6,137

(1) Net revenues of the Pharmacy Services Segment include approximately $8.4 billion, $7.9 billion and $6.6 billion of Retail Co-Payments for 2012, 2011 and 2010, respectively. See Note 1 to the consolidated financial statements for additional information about Retail Co-Payments.

(2) Intersegment eliminations relate to two types of transactions: (i) Intersegment revenues that occur when Pharmacy Services Segment customers use Retail Pharmacy Segment stores to purchase covered products. When this occurs, both the Pharmacy Services and Retail Pharmacy segments record the revenue on a standalone basis, and (ii) Intersegment revenues, gross profit and operating profit that occur when Pharmacy Services Segment customers, through the Company's intersegment activities (such as the Maintenance Choice® program), elect to pick-up their maintenance prescriptions at Retail Pharmacy Segment stores instead of receiving them through the mail. When this occurs, both the Pharmacy Services and Retail Pharmacy segments record the revenue, gross profit and operating profit on a standalone basis. Beginning in the fourth quarter of 2011, the Maintenance Choice eliminations reflect all discounts available for the purchase of mail order prescription drugs. The following amounts are eliminated in consolidation in connection with the item (ii) intersegment activity: net revenues of $3.4 billion, $2.6 billion and $1.8 billion for the years ended December 31, 2012, 2011 and 2010, respectively; gross profit and operating profit of $411 million, $186 million and $135 million for the years ended December 31, 2012, 2011 and 2010, respectively.

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Pharmacy Services Segment

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

In millions	Year Ended December 31, 2012	2011	2010
Net revenues	$ 73,444	$58,874	$47,145
Gross profit	3,808	3,279	3,315
Gross profit % of net revenues	5.2%	5.6%	7.0%
Operating expenses	1,129	1,059	954
Operating expenses % of net revenues	1.5%	1.8%	2.0%
Operating profit	2,679	2,220	2,361
Operating profit % of net revenues	3.7%	3.8%	5.0%
Net revenues[1]:			
Mail choice[2]	$ 22,843	$18,616	$16,159
Pharmacy network[3]	50,411	40,040	30,681
Other	190	218	305
Pharmacy claims processed[1]:			
Total	880.5	774.6	584.7
Mail choice[2]	81.7	70.6	64.1
Pharmacy network[3]	798.8	704.0	520.6
Generic dispensing rate[1]:			
Total	78.5%	74.1%	71.5%
Mail choice[2]	72.0%	64.9%	61.3%
Pharmacy network[3]	79.1%	75.0%	72.7%
Mail choice penetration rate	22.7%	22.3%	25.8%

(1) Pharmacy network net revenues, claims processed and generic dispensing rates do not include Maintenance Choice, which are included within the mail choice category.

(2) Mail choice is defined as claims filled at a Pharmacy Services' mail facility, which includes specialty mail claims, as well as 90-day claims filled at retail under the Maintenance Choice program.

(3) Pharmacy network is defined as claims filled at retail pharmacies, including our retail drugstores, but excluding Maintenance Choice activity.

Net revenues in our Pharmacy Services Segment increased $14.6 billion, or 24.7%, to $73.4 billion for the year ended December 31, 2012, as compared to the prior year. The increase in net revenues was primarily due to new client starts on January 1, 2012, drug cost inflation and the growth of our Medicare Part D program. Conversely, the increase in our generic dispensing rate had a negative impact on our revenue in 2012 as it did in 2011.

Net revenues increased $11.7 billion, or 24.9%, to $58.9 billion for the year ended December 31, 2011, as compared to the prior year. The increase in 2011 was primarily due to the addition of the long-term contract with Aetna Inc. ("Aetna"), which became effective on January 1, 2011, as well as activity resulting from our April 29, 2011 acquisition of the UAM Medicare Part D Business. Additionally, the increase in our generic dispensing rate had a negative impact on our revenue in 2011 as it did in 2010.

As you review our Pharmacy Services Segment's revenue performance, we believe you should also consider the following important information:

- Our mail choice claims processed increased 15.7% to 81.7 million claims in the year ended December 31, 2012, compared to 70.6 million claims in the prior year. The increase in mail choice claim volume was primarily due to a significant number of 2012 new client starts, as well as increased claims associated with the continuing client adoption of our Maintenance Choice program. During 2011, our mail choice claims processed increased 10.2% to 70.6 million claims. The increase in mail choice claim volume was primarily due to the addition of the long-term contract with Aetna, which became effective on January 1, 2011.
- During 2012 and 2011, our average revenue per mail choice claim increased by 6.0% and 4.6%, compared to 2011 and 2010, respectively. This increase was primarily due to drug cost inflation particularly in our specialty business.
- Our mail choice generic dispensing rate was 72.0%, 64.9% and 61.3% in the years ended December 31, 2012, 2011 and 2010, respectively.
- Our pharmacy network generic dispensing rate increased to 79.1% in the year ended December 31, 2012, compared to 75.0% in the prior year. During 2011, our pharmacy network generic dispensing rate increased to 75.0% compared to our pharmacy network generic dispensing rate of 72.7% in 2010. These continued increases in both mail choice and pharmacy network generic dispensing rates were primarily due to the impact of new generic drug introductions and our continuous efforts to encourage plan members to use generic drugs when they are available. We believe our generic dispensing rates will continue to increase in future periods. This increase will be affected by, among other things, the number of new generic drug introductions and our success at encouraging plan members to utilize generic drugs when they are available and clinically appropriate.
- Our pharmacy network claims processed increased 13.5% to 798.8 million claims in the year ended December 31, 2012, compared to 704.0 million claims in the prior year. The increase in the pharmacy network claim volume was primarily due to a large number of 2012 new client starts, as well as higher claims activity associated with our Medicare Part D program. During 2011, our pharmacy network claims processed increased 35.2% to 704.0 million compared to 520.6 million pharmacy network claims processed in 2010. The increase in the pharmacy network claim volume was primarily due to the addition of the long-term contract with Aetna, which became effective on January 1, 2011. Additionally, we experienced higher claims activity associated with our Medicare Part D program as a result of our acquisition of the UAM Medicare Part D Business completed during the second quarter of 2011 and increases in covered lives under our legacy Medicare Part D program.
- Our average revenue per pharmacy network claim processed increased 11.0% in the year ended December 31, 2012 as compared to the prior year. This increase was primarily due to drug cost inflation partially offset by increases in the generic dispensing rate. During 2011, our average revenue per pharmacy network claim processed decreased by 3.5%, compared to 2010. This decrease was primarily due to increases in the percentage of generic prescription drugs dispensed, changes in client pricing, and the impact of our acquisition of the UAM Medicare Part D Business, partially offset by our long-term contract with Aetna, which became effective on January 1, 2011.
- During 2012, 2011, and 2010, we generated net revenues from our participation in the administration of the Medicare Part D drug benefit by providing PBM services to our health plan clients and other clients that have qualified as a Medicare Part D Prescription Drug Plan (a "PDP") under regulations promulgated by the Centers for Medicare and Medicaid Services ("CMS"). We are also a national provider of drug benefits to eligible beneficiaries under the Medicare Part D program through our subsidiaries, SilverScript and Pennsylvania Life (which have been approved by CMS as PDPs).
- The Pharmacy Services Segment recognizes revenues for its pharmacy network transactions based on individual contract terms. In accordance with ASC 605, *Revenue Recognition*, Caremark's contracts are predominantly accounted for using the gross method.

Gross profit in our Pharmacy Services Segment includes net revenues less cost of revenues. Cost of revenues includes (i) the cost of pharmaceuticals dispensed, either directly through our mail service and specialty retail pharmacies or indirectly through our pharmacy network, (ii) shipping and handling costs and (iii) the operating costs of our mail service pharmacies, customer service operations and related information technology support.

Gross profit increased $529 million, or 16.1%, to $3.8 billion in the year ended December 31, 2012, as compared to the prior year. Gross profit as a percentage of net revenues was 5.2% for the year ended December 31, 2012, compared to 5.6% in the prior year. The increase in gross profit dollars in the year ended December 31, 2012 was primarily due to a significant number of 2012 new client starts, an increase in generic dispensing and drug cost inflation. The decrease in gross profit as a percentage of revenue was driven primarily by client pricing compression, increased payroll and other expenses associated with our mail and specialty operations, and expanding Medicare Part D operations, which has lower margins. The increase in expenses associated with our mail operations was the result of the significant number of 2012 new client starts.

During 2011, gross profit decreased $36 million, or 1.1%, to $3.3 billion for the year ended December 31, 2011, as compared to the prior year. Gross profit as a percentage of net revenues was 5.6% for the year ended December 31, 2011, compared to 7.0% in the prior year. The decrease in gross profit dollars in the year ended December 31, 2011 was primarily driven by pricing compression relating to contract renewals and in particular the renewal of a large government client contract that took effect during the third quarter of 2010 partially offset by activity associated with our April 2011 acquisition of the UAM Medicare Part D Business.

During the year ended December 31, 2011, the decrease in gross profit as a percentage of net revenues was also driven by the previously mentioned client pricing compression, as well as the profitability associated with our long-term contract with Aetna, which has lower margins. These factors were partially offset by the positive impact from the above mentioned increases in our generic dispensing rates as compared to the prior year.

As you review our Pharmacy Services Segment's performance in this area, we believe you should consider the following important information:

- Our gross profit dollars and gross profit as a percentage of net revenues continued to be impacted by our efforts to (i) retain existing clients, (ii) obtain new business and (iii) maintain or improve the rebates and/or discounts we received from manufacturers, wholesalers and retail pharmacies. In particular, competitive pressures in the PBM industry have caused us and other PBMs to continue to share a larger portion of rebates and/or discounts received from pharmaceutical manufacturers. In addition, market dynamics and regulatory changes have impacted our ability to offer plan sponsors pricing that includes retail network "differential" or "spread". We expect these trends to continue. The "differential" or "spread" is any difference between the drug price charged to plan sponsors, including Medicare Part D plan sponsors, by a PBM and the price paid for the drug by the PBM to the dispensing provider. The increased use of generic drugs has positively impacted our gross profit margins but has resulted in third party payors augmenting their efforts to reduce reimbursement payments for prescriptions. This trend, which we expect to continue, reduces the benefit we realize from brand to generic product conversions.
- We review our network contracts on an individual basis to determine if the related revenues should be accounted for using the gross method or net method under the applicable accounting rules. Caremark's network contracts are predominantly accounted for using the gross method, which results in higher revenues, higher cost of revenues and lower gross profit rates. The conversion of certain RxAmerica contracts to the Caremark contract structure increased our net revenues, increased our cost of revenues and lowered our gross profit rates in 2010. Although this change did not affect our gross profit dollars, it did reduce our gross profit rates by approximately 40 basis points in the year ended December 31, 2010.
- Our gross profit as a percentage of revenues benefited from the increase in our total generic dispensing rate, which increased to 78.5% and 74.1% in 2012 and 2011, respectively, compared to our generic dispensing rate of 71.5% in 2010. These increases were primarily due to new generic drug introductions and our continued efforts to encourage plan members to use generic drugs when they are available. We expect these trends to continue, albeit at a slower pace.
- Effective January 1, 2010, CMS issued a regulation requiring that any differential or spread between the drug price charged to Medicare Part D plan sponsors by a PBM and the price paid for the drug by the PBM to the dispensing provider be reported as an administrative cost rather than a drug cost of the plan sponsor for purposes of calculating certain government subsidy payments and the drug price to be charged to enrollees. As noted above, these changes have impacted our ability to offer Medicare Part D plan sponsors pricing that includes the use of retail network differential or spread. This change impacted both our gross profit dollars and gross profit as a percentage of net revenues in 2011 and 2010.
- As discussed in Note 13 to our consolidated financial statements, effective January 15, 2013, CMS imposed certain sanctions on our SilverScript Medicare Part D PDP. These sanctions and the remediation efforts that may be required to address issues resulting from our 2013 Medicare Part D enrollment systems conversion process and related plan consolidation efforts may have an adverse impact on the profitability of our Pharmacy Services Segment. Please see "Cautionary Statement Concerning Forward-Looking Statements" section later in Management's Discussion and Analysis of Financial Condition and Results of Operations.

Operating expenses in our Pharmacy Services Segment, which include selling, general and administrative expenses, depreciation and amortization related to selling, general and administrative activities and retail specialty pharmacy store and administrative payroll, employee benefits and occupancy costs, decreased to 1.5% of net revenues in 2012 compared to 1.8% and 2.0% in 2011 and 2010, respectively.

As you review our Pharmacy Services Segment's performance in this area, we believe you should consider the following important information:

- Operating expenses increased $70 million or 6.6%, to $1.1 billion, in the year ended December 30, 2012, compared to the prior year. The increase in operating expenses is primarily related to increased costs associated with the expansion of our Medicare Part D business. The decrease in operating expenses as a percentage of net revenues is primarily due to expense leverage from net revenue growth and expense control initiatives.
- During 2011, the increase in operating expenses of $105 million or approximately 11%, to $1.1 billion compared to 2010, is primarily related to normal operating expenses of the acquired UAM Medicare Part D Business, costs associated with changes designed to streamline our business, expenses associated with the acquisition and integration of the UAM Medicare Part D Business, partially offset by disciplined expense management.

Retail Pharmacy Segment

The following table summarizes our Retail Pharmacy Segment's performance for the respective periods:

	Year Ended December 31,		
In millions	**2012**	**2011**	**2010**
Net revenues	$ 63,654	$ 59,599	$ 57,345
Gross profit	19,109	17,468	17,039
Gross profit % of net revenues	30.0%	29.3%	29.7%
Operating expenses	13,455	12,556	12,502
Operating expenses % of net revenues	21.1%	21.1%	21.8%
Operating profit	5,654	4,912	4,537
Operating profit % of net revenues	8.9%	8.2%	7.9%
Retail prescriptions filled (90 Day = 1 prescription)	717.9	657.8	636.3
Retail prescriptions filled (90 Day = 3 prescriptions) (1)	848.1	763.4	723.1
Net revenue increase:			
Total	6.8%	3.9%	3.6%
Pharmacy	7.6%	4.4%	4.1%
Front Store	5.1%	3.0%	2.6%
Total prescription volume (90 Day = 1 prescription)	9.1%	3.4%	3.2%
Total prescription volume (90 Day = 3 prescriptions) (1)	11.1%	5.6%	6.1%
Same store sales increase:			
Total	5.5%	2.3%	2.1%
Pharmacy	6.5%	3.1%	2.9%
Front Store	3.4%	0.8%	0.5%
Prescription volume (90 Day = 1 prescription)	8.1%	2.2%	2.1%
Prescription volume (90 Day = 3 prescriptions) (1)	10.3%	4.4%	6.4%
Generic dispensing rates	79.2%	75.6%	73.0%
Pharmacy % of net revenues	68.8%	68.3%	68.0%
Third party % of pharmacy revenue	97.5%	97.8%	97.4%

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

Net revenues increased $4.1 billion, or 6.8%, to $63.7 billion for the year ended December 31, 2012, as compared to the prior year. This increase was primarily driven by a same store sales increase of 5.5% and net revenues from new stores, which accounted for approximately 110 basis points of our total net revenue percentage increase during the year.

Net revenues in our Retail Pharmacy Segment increased $2.3 billion, or 3.9% to $59.6 billion for the year ended December 31, 2011, as compared to the prior year. This increase was primarily driven by a same store sales increase of 2.3% and net revenues from new stores, which accounted for approximately 130 basis points of our total net revenue percentage increase during the year. Additionally, we continued to see a positive impact on our net revenues due to the growth of our Maintenance Choice program.

As you review our Retail Pharmacy Segment's performance in this area, we believe you should consider the following important information:

- Front store same store sales rose 5.1% in the year ended December 31, 2012, as compared to the prior year. Front store same store sales were positively impacted by increased customer traffic resulting from new store growth, the contractual impasse between Express Scripts and Walgreens and an additional day as a result of 2012 being a leap year.
- Pharmacy same store sales rose 7.6% in the year ended December 31, 2012, as compared to the prior year. The contractual impasse between Express Scripts and Walgreens was a significant driver of the increase. Pharmacy same store sales also benefited from an additional day as a result of 2012 being a leap year.
- Pharmacy revenues continue to be negatively impacted by the conversion of brand name drugs to equivalent generic drugs, which typically have a lower selling price. Pharmacy same store sales were negatively impacted by approximately 700 and 215 basis points for the years ended December 31, 2012 and 2011, respectively, due to recent generic introductions. In addition, our pharmacy growth has also been adversely affected by the lack of significant new brand name drug introductions, higher consumer co-payments and co-insurance arrangements and an increase in the number of over-the-counter remedies that were historically only available by prescription.
- As of December 31, 2012, we operated 7,458 retail stores compared to 7,327 retail stores as of December 31, 2011 and 7,182 retail stores as of December 31, 2010. Total net revenues from new stores (excluding acquired stores) contributed approximately 1.1%, 1.3% and 1.4% to our total net revenue percentage increase in 2012, 2011, and 2010, respectively.
- Pharmacy revenue growth continued to benefit from increased utilization by Medicare Part D beneficiaries, the ability to attract and retain managed care customers and favorable industry trends. These trends include an aging American population; many "baby boomers" are now in their fifties and sixties and are consuming a greater number of prescription drugs. In addition, the increased use of pharmaceuticals as the first line of defense for individual health care also contributed to the growing demand for pharmacy services. We believe these favorable industry trends will continue.

Gross profit in our Retail Pharmacy Segment includes net revenues less the cost of merchandise sold during the reporting period and the related purchasing costs, warehousing costs, delivery costs and actual and estimated inventory losses.

Gross profit increased $1.6 billion, or 9.4%, to $19.1 billion in the year ended December 31, 2012, as compared to the prior year. Gross profit as a percentage of net revenues increased to 30.0% in year ended December 31, 2012, from 29.3% in 2011. The increase in gross profit dollars in the year ended December 31, 2012, was primarily driven by same store sales increases. The increase in gross profit as a percentage of revenue was primarily driven by increased pharmacy margins due to the positive impact of increased generic drugs dispensed, partially offset by continued reimbursement pressure and lower front store margins.

Gross profit increased $429 million, or 2.5%, to $17.5 billion for the year ended December 31, 2011, as compared to the prior year. Gross profit as a percentage of net revenues decreased to 29.3% for the year ended December 31, 2011, compared to 29.7% for the prior year. Gross profit as a percentage of revenue was negatively impacted during 2011 by lower pharmacy margins due to continued reimbursement pressure which was partially offset by the positive impact of increased generic drugs dispensed.

As you review our Retail Pharmacy Segment's performance in this area, we believe you should consider the following important information:

- Gross profit was positively impacted by approximately $31 million for the year ended December 31, 2012 as a result of the change in inventory accounting methods described in Note 2 to our consolidated financial statements. The impact of this change on gross profit as a percentage of net revenues for the year ended December 31, 2012 was approximately five basis points.
- On average, our gross profit on front-store revenues is generally higher than our average gross profit on pharmacy revenues. Front-store revenues were 31.2%, 31.7% and 32.0% of total revenues, in 2012, 2011 and 2010, respectively. Pharmacy revenues were 68.8%, 68.3% and 68.0% of total revenues, in 2012, 2011 and 2010, respectively. This shift in sales mix had a negative effect on our overall gross profit for the year ended December 31, 2012 and 2011, respectively.
- During 2011, our front-store gross profit rate was positively impacted by private label and proprietary brand product sales, which normally yield a higher gross profit rate than other front-store products.
- Our pharmacy gross profit rates have been adversely affected by the efforts of managed care organizations, pharmacy benefit managers and governmental and other third-party payors to reduce their prescription drug costs. In the event this trend continues, we may not be able to sustain our current rate of revenue growth and gross profit dollars could be adversely impacted.

- The increased use of generic drugs has positively impacted our gross profit margins but has resulted in third party payors augmenting their efforts to reduce reimbursement payments to retail pharmacies for prescriptions. This trend, which we expect to continue, reduces the benefit we realize from brand to generic product conversions.
- Sales to customers covered by third party insurance programs are a large component of our total pharmacy business. On average, our gross profit on third party pharmacy revenues is lower than our gross profit on cash pharmacy revenues. Third party pharmacy revenues were 97.5% of pharmacy revenues in 2012, compared to 97.8% and 97.4% of pharmacy revenues in 2011 and 2010, respectively.
- The Medicare Part D program is increasing prescription utilization. However, it is also decreasing our pharmacy gross profit rates as our higher gross profit business continued to migrate to Part D coverage during 2012, 2011 and 2010.
- The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, "ACA") made several significant changes to Medicaid rebates and to reimbursement. One of these changes was to revise the definition of Average Manufacturer Price and the reimbursement formula for multi-source drugs. CMS has not yet issued final regulations implementing these changes. Therefore, we cannot predict the effect these changes will have on Medicaid reimbursement or their impact on the Company. See "Government Regulation" within Part I, Item 1, Business, for additional information.

Operating expenses in our Retail Pharmacy Segment include store payroll, store employee benefits, store occupancy costs, selling expenses, advertising expenses, depreciation and amortization expense and certain administrative expenses.

Operating expenses increased $899 million, or 7.2% to $13.5 billion, or 21.1% as a percentage of net revenues, in the year ended December 31, 2012, as compared to $12.6 billion, or 21.1% as a percentage of net revenues, in the prior year. Operating expenses as a percentage of net revenues remained consistent with the prior year period. The increase in operating expense dollars was the result of higher store operating costs associated with our increased store count.

Operating expenses increased $54 million, or less than 1%, to $12.6 billion, or 21.1% as a percentage of net revenues, in the year ended December 31, 2011, as compared to $12.5 billion, or 21.8% as a percentage of net revenues, in the prior year. We saw improvement in operating expenses as a percentage of net revenues for the year ended December 31, 2011, due to improved expense leverage from our same store sales growth and expense control initiatives.

Corporate Segment

Operating expenses increased $78 million, or 12.5%, to $694 million in the year ended December 31, 2012, as compared to the prior year. Operating expenses decreased $10 million, or 1.6% during 2011. Operating expenses within the Corporate Segment include executive management, corporate relations, legal, compliance, human resources, corporate information technology and finance related costs.

The increase in operating expenses in 2012 was primarily due to higher benefit costs and information technology expenses. The decrease in operating expenses in 2011 was primarily driven by lower professional fees for legal services and lower consulting costs.

Liquidity and Capital Resources

We maintain a level of liquidity sufficient to allow us to cover our cash needs in the short-term. Over the long-term, we manage our cash and capital structure to maximize shareholder return, maintain our financial position and maintain flexibility for future strategic initiatives. We continuously assess our working capital needs, debt and leverage levels, capital expenditure requirements, dividend payouts, potential share repurchases and future investments or acquisitions. We believe our operating cash flows, commercial paper program, sale-leaseback program, as well as any potential future borrowings, will be sufficient to fund these future payments and long-term initiatives.

Net cash provided by operating activities was $6.7 billion for the year ended December 31, 2012, compared to $5.9 billion in 2011, and $4.8 billion in 2010. The increase in 2012 was primarily due to the significant increase in net income, improved receivables management, improved payables management, and the timing of payments. The increase in 2011 was related to improvements in inventory and payables management, increases in accrued expenses due to the timing of payments and growth in claims payable due to increased volume of activity in our Pharmacy Services Segment, partially offset by increased accounts receivable.

Net cash used in investing activities was $1.8 billion, representing a decrease of $561 million in 2012. This compares to approximately $2.4 billion and $1.6 billion in 2011 and 2010, respectively. The decrease in 2012 was primarily due to the $1.3 billion acquisition of the UAM Medicare Part D Business which occurred in April 2011. In 2011, the increase in net cash used in investing activities was primarily due to the cash paid to acquire the UAM Medicare Part D Business, partially offset by the proceeds from the sale of our TheraCom subsidiary, increased proceeds from sale-lease back transactions and lower purchases of property and equipment.

In 2012, gross capital expenditures totaled $2.0 billion, an increase of $158 million compared to the prior year. During 2012, approximately 45% of our total capital expenditures were for new store construction, 40% were for store expansion and improvements and 15% were for technology and other corporate initiatives. Gross capital expenditures totaled approximately $1.9 billion during 2011, compared to approximately $2.0 billion in 2010. The decrease in gross capital expenditures during 2011 was primarily due to the absence of spending which occurred in 2010 related to store remodeling. During 2011, approximately 46% of our total capital expenditures were for new store construction, 18% were for store expansion and improvements and 36% were for technology and other corporate initiatives.

Proceeds from sale-leaseback transactions totaled $529 million in 2012. This compares to $592 million in 2011 and $507 million in 2010. Under the sale-leaseback transactions, the properties are generally sold at net book value, which generally approximates fair value, and the resulting leases qualify and are accounted for as operating leases. The specific timing and amount of future sale-leaseback transactions will vary depending on future market conditions and other factors.

Following is a summary of our store development activity for the respective years:

	2012[2]	2011[2]	2010[2]
Total stores (beginning of year)	7,388	7,248	7,095
New and acquired stores[1]	150	162	183
Closed stores[1]	(30)	(22)	(30)
Total stores (end of year)	7,508	7,388	7,248
Relocated stores	90	86	106

(1) Relocated stores are not included in new or closed store totals.

(2) Excludes specialty mail order facilities.

Net cash used in financing activities was approximately $4.9 billion in 2012, compared to net cash used in financing activities of $3.5 billion in 2011 and net cash used in financing activities of $2.8 billion in 2010. Net cash used in financing activities during 2012 was primarily related to $4.3 billion of share repurchases associated with the share repurchase programs discussed below, the repurchase of long-term debt for $1.7 billion, partially offset by the issuance of approximately $1.2 billion of long-term debt. Net cash used in financing activities during 2011 was primarily due to $3.0 billion of share repurchases associated with the share repurchase program, as well as a net reduction in our outstanding debt of $0.2 billion. Net cash used in financing activities during 2010 was primarily due to the repayment of long-term-debt of approximately $2.1 billion and $1.5 billion of share repurchases associated with the share repurchase programs, partially offset by net proceeds from the issuance of long-term debt of approximately $1 billion.

Share repurchase programs – On September 19, 2012, the Company's Board of Directors authorized a new share repurchase program for up to $6.0 billion of outstanding common stock (the "2012 Repurchase Program"). The share repurchase authorization, which was effective immediately, permits the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase transactions, and/or other derivative transactions. The 2012 Repurchase Program may be modified or terminated by the Board of Directors at any time.

On August 23, 2011, our Board of Directors authorized a share repurchase program for up to $4.0 billion of outstanding common stock (the "2011 Repurchase Program"). The share repurchase authorization, which was effective immediately, permits us to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase transactions, and/or other derivative transactions.

Pursuant to the authorizations under the 2011 and 2012 Repurchase Programs, on September 19, 2012, we entered into a $1.2 billion fixed dollar accelerated share repurchase ("ASR") agreement with Barclays Bank PLC ("Barclays"). Upon payment of the $1.2 billion purchase price on September 20, 2012, we received a number of shares of our common stock equal to 50% of the $1.2 billion notional amount of the ASR agreement or approximately 12.6 million shares at a price of $47.71 per share. We received approximately 13.0 million shares of common stock on November 16, 2012 at an average price of $46.96 per share, representing the remaining 50% of the $1.2 billion notional amount of the ASR agreement and thereby concluding the agreement. The total of 25.6 million shares of common stock delivered to us by Barclays over the term of the ASR agreement were placed into treasury stock.

Pursuant to the authorization under the 2011 Repurchase Program, on August 24, 2011, we entered into a $1.0 billion fixed dollar ASR agreement with Barclays. The ASR agreement contained provisions that establish the minimum and maximum number of shares to be repurchased during its term. Pursuant to the ASR agreement, on August 25, 2011, we paid $1.0 billion to Barclays in exchange for Barclays delivering 20.3 million shares of common stock to us. On September 16, 2011, upon establishment of the minimum number of shares to be repurchased, Barclays delivered an additional 5.4 million shares of common stock to us. At the conclusion of the transaction on December 28, 2011, Barclays delivered a final installment of 1.6 million shares of common stock on December 29, 2011. The aggregate 27.3 million shares of common stock delivered to us by Barclays, were placed into treasury stock. This represented all the repurchases that occurred during the year ended December 31, 2011 under the 2011 Repurchase Program.

During the year ended December 31, 2012, we repurchased an aggregate of 95.0 million shares of common stock for approximately $4.3 billion under the 2012 and 2011 Repurchase Programs. As of December 31, 2012, the 2011 Repurchase Program was complete and there remained approximately $4.7 billion available for future repurchases under the 2012 Repurchase Program.

On June 14, 2010, our Board of Directors authorized a share repurchase program for up to $2.0 billion of our outstanding common stock (the "2010 Repurchase Program"). During the year ended December 31, 2011, we repurchased an aggregate of 56.4 million shares of common stock for approximately $2.0 billion, completing the 2010 Repurchase Program.

On November 4, 2009, our Board of Directors authorized a share repurchase program for up to $2.0 billion of our outstanding common stock (the "2009 Repurchase Program"). During 2010, we repurchased 42.4 million shares of common stock for approximately $1.5 billion, completing the 2009 Repurchase Program.

Short-term borrowings - We had $690 million of commercial paper outstanding at a weighted average interest rate of 0.35% as of December 31, 2012. In connection with our commercial paper program, we maintain a $1.0 billion, three-year unsecured back-up credit facility, which expires on May 27, 2013, a $1.25 billion, four-year unsecured back-up credit facility, which expires on May 12, 2015 and a $1.25 billion, five-year unsecured back-up credit facility, which expires on February 17, 2017. The credit facilities allow for borrowings at various rates that are dependent, in part, on our public debt ratings and require us to pay a weighted average quarterly facility fee of approximately 0.05%, regardless of usage. As of December 31, 2012, there were no borrowings outstanding under the back-up credit facilities. We intend to renew our back-up credit facility that expires in May 2013.

Long-term borrowings - On November 26, 2012, we issued $1.25 billion of 2.75% unsecured senior notes due December 1, 2022 (the "2012 Notes") for total proceeds of approximately $1.24 billion, net of discounts and underwriting fees. The 2012 Notes pay interest semi-annually and may be redeemed, in whole at any time, or in part from time to time, at our option at a defined redemption price plus accrued and unpaid interest to the redemption date. The net proceeds of the 2012 Notes were used for general corporate purposes and to repay certain corporate debt.

Also on November 26, 2012, we announced tender offers for any and all of the 6.6% Senior Notes due 2019, and up to a maximum amount of the 6.125% Senior Notes due 2016 and 5.75% Senior Notes due 2017, for up to an aggregate principal amount of $1.0 billion. In December 2012, we increased the aggregate principal amount of the tender offers to $1.325 billion and completed the repurchase for the maximum amount. We paid a premium of $332 million in excess of the debt principal in connection with the tender offers, wrote off $13 million of unamortized deferred financing costs and incurred $3 million in fees, for a total loss on the early extinguishment of debt of $348 million. The loss was recorded in income from continuing operations on the consolidated statement of income.

In connection with our acquisition of the UAM Medicare Part D Business in April 2011, we assumed $110 million of long-term debt in the form of Trust Preferred Securities that mature through 2037. During the years ended December 31, 2012 and 2011, we repaid $50 million and $60 million, respectively, of the Trust Preferred Securities at par.

On May 12, 2011, we issued $550 million of 4.125% unsecured senior notes due May 15, 2021 and issued $950 million of 5.75% unsecured senior notes due May 15, 2041 (collectively, the "2011 Notes") for total proceeds of approximately $1.5 billion, net of discounts and underwriting fees. The 2011 Notes pay interest semi-annually and may be redeemed, in whole at any time, or in part from time to time, at our option at a defined redemption price plus accrued and unpaid interest to the redemption date. The net proceeds of the 2011 Notes were used to repay commercial paper borrowings and certain other corporate debt, and were used for general corporate purposes.

In December 2011 and July 2012, we repurchased $958 million and $1 million of the principal amount of our Enhanced Capital Advantaged Preferred Securities ("ECAPS") at par. The fees and write-off of deferred issuance costs associated with the early extinguishment of the ECAPS were de minimis. The remaining $41 million of outstanding ECAPS at December 31, 2012 are due in 2062 and bear interest at 6.302% per year until June 1, 2012, at which time they will pay interest based on a floating rate. The ECAPS pay interest semi-annually and may be redeemed at any time, in whole or in part at a defined redemption price plus accrued interest.

On May 13, 2010, we issued $550 million of 3.25% unsecured senior notes due May 18, 2015 and issued $450 million of 4.75% unsecured senior notes due May 18, 2020 (collectively, the "2010 Notes") for total proceeds of $991 million, which was net of discounts and underwriting fees. The 2010 Notes pay interest semi-annually and may be redeemed, in whole at any time, or in part from time to time, at the Company's option at a defined redemption price plus accrued and unpaid interest to the redemption date. The net proceeds of the 2010 Notes were used to repay a portion of the Company's outstanding commercial paper borrowings, certain other corporate debt and for general corporate purposes.

Our backup credit facility, unsecured senior notes and ECAPS (see Note 7 to the Consolidated Financial Statements) contain customary restrictive financial and operating covenants.

These covenants do not include a requirement for the acceleration of our debt maturities in the event of a downgrade in our credit rating. We do not believe the restrictions contained in these covenants materially affect our financial or operating flexibility.

As of December 31, 2012 and 2011, we had no outstanding derivative financial instruments.

Debt Ratings - As of December 31, 2012, our long-term debt was rated "Baa2" by Moody's with a positive outlook and "BBB+" by Standard & Poor's with a stable outlook, and our commercial paper program was rated "P-2" by Moody's and "A-2" by Standard & Poor's. In assessing our credit strength, we believe that both Moody's and Standard & Poor's considered, among other things, our capital structure and financial policies as well as our consolidated balance sheet, our historical acquisition activity and other financial information. Although we currently believe our long-term debt ratings will remain investment grade, we cannot guarantee the future actions of Moody's and/or Standard & Poor's. Our debt ratings have a direct impact on our future borrowing costs, access to capital markets and new store operating lease costs.

Quarterly Dividend Increase - In December 2012, our Board of Directors authorized a 38% increase in our quarterly common stock dividend to $0.225 per share. This increase equates to an annual dividend rate of $0.90 per share. In December 2011, our Board of directors authorized a 30% increase in our quarterly common stock dividend to $0.1625 per share. This increase equated to an annual dividend rate of $0.65 per share. On January 11, 2011, our Board of Directors authorized a 43% increase in our quarterly common stock dividend to $0.125 per share. This increase equated to an annual dividend rate of $0.50 per share. In January 2010, our Board of Directors authorized a 15% increase in our quarterly common stock dividend to $0.0875 per share. This increase equated to an annual dividend rate of $0.35 per share.

Off-Balance Sheet Arrangements

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

Between 1991 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores, Linens 'n Things, Marshalls, Kay-Bee Toys, This End Up and Footstar. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the store's lease obligations. When the subsidiaries were disposed of, the Company's guarantees remained in place, although each initial purchaser has indemnified the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries were to become insolvent and failed to make the required payments under a store lease, the Company could be required to satisfy these obligations.

As of December 31, 2012, the Company guaranteed approximately 74 such store leases (excluding the lease guarantees related to Linens 'n Things), with the maximum remaining lease term extending through 2022. Management believes the ultimate disposition of any of the remaining lease guarantees will not have a material adverse effect on the Company's consolidated financial condition or future cash flows. Please see "Income (loss) from discontinued operations" previously in this document for further information regarding our guarantee of certain Linens 'n Things' store lease obligations.

Following is a summary of our significant contractual obligations as of December 31, 2012:

	Payments Due by Period				
In millions	**Total**	**2013**	**2014 to 2015**	**2016 to 2017**	**Thereafter**
Operating leases	$27,596	$2,261	$4,097	$3,802	$17,436
Leases from discontinued operations	93	21	36	24	12
Long-term debt	8,967	1	1,100	1,731	6,135
Interest payments on long-term debt[(1)]	6,545	472	897	813	4,363
Other long-term liabilities reflected in our consolidated balance sheet	512	39	152	104	217
Capital lease obligations	336	20	42	42	232
	$44,049	$2,814	$6,324	$6,516	$28,395

(1) Interest payments on long-term debt are calculated on outstanding balances and interest rates in effect on December 31, 2012.

Critical Accounting Policies

We prepare our consolidated financial statements in conformity with generally accepted accounting principles, which require management to make certain estimates and apply judgment. We base our estimates and judgments 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, we review our accounting policies and how they are applied and disclosed in our consolidated financial statements. While we believe the historical experience, current trends and other factors considered, support the preparation of our consolidated financial statements in conformity with generally accepted accounting principles, actual results could differ from our estimates, and such differences could be material.

Our significant accounting policies are discussed in Note 1 to our consolidated financial statements. We believe the following accounting policies include a higher degree of judgment and/or complexity and, thus, are considered to be critical accounting policies. We have discussed the development and selection of our critical accounting policies with the Audit Committee of our Board of Directors and the Audit Committee has reviewed our disclosures relating to them.

Revenue Recognition

Pharmacy Services Segment

Our Pharmacy Services Segment sells prescription drugs directly through our mail service pharmacies and indirectly through our retail pharmacy network. We recognize revenues in our Pharmacy Services Segment from prescription drugs sold by our mail service pharmacies and under retail pharmacy network contracts where we are the principal using the gross method at the contract prices negotiated with our clients. Net revenue from our Pharmacy Services Segment includes: (i) the portion of the price the client pays directly to us, net of any volume-related or other discounts paid back to the client, (ii) the price paid to us ("Mail Co-Payments") or a third party pharmacy in our retail pharmacy network ("Retail Co-Payments") by individuals included in our clients' benefit plans, and (iii) administrative fees for retail pharmacy network contracts where we are not the principal.

We recognize revenue in the Pharmacy Services Segment when: (i) persuasive evidence of an arrangement exists, (ii) delivery has occurred or services have been rendered, (iii) the seller's price to the buyer is fixed or determinable, and (iv) collectability is reasonably assured. The following revenue recognition policies have been established for the Pharmacy Services Segment.

- Revenues generated from prescription drugs sold by mail service pharmacies are recognized when the prescription is shipped. At the time of shipment, the Pharmacy Services Segment has performed substantially all of its obligations under its client contracts and does not experience a significant level of returns or reshipments.

- Revenues generated from prescription drugs sold by third party pharmacies in the Pharmacy Services Segment's retail pharmacy network and associated administrative fees are recognized at the Pharmacy Services Segment's point-of-sale, which is when the claim is adjudicated by the Pharmacy Services Segment's online claims processing system.

We determine whether we are the principal or agent for our retail pharmacy network transactions on a contract by contract basis. In the majority of our contracts, we have determined we are the principal due to us: (i) being the primary obligor in the arrangement, (ii) having latitude in establishing the price, changing the product or performing part of the service, (iii) having discretion in supplier selection, (iv) having involvement in the determination of product or service specifications, and (v) having credit risk. Our obligations under our client contracts for which revenues are reported using the gross method are separate and distinct from our obligations to the third party pharmacies included in our retail pharmacy network contracts. Pursuant to these contracts, we are contractually required to pay the third party pharmacies in our retail pharmacy network for products sold, regardless of whether we are paid by our clients. Our responsibilities under these client contracts typically include validating eligibility and coverage levels, communicating the prescription

price and the co-payments due to the third party retail pharmacy, identifying possible adverse drug interactions for the pharmacist to address with the physician prior to dispensing, suggesting clinically appropriate generic alternatives where appropriate and approving the prescription for dispensing. Although we do not have credit risk with respect to Retail Co-Payments, we believe that all of the other indicators of gross revenue reporting are present. For contracts under which we act as an agent, we record revenues using the net method.

We deduct from our revenues the manufacturers' rebates that are earned by our clients based on their members' utilization of brand-name formulary drugs. We estimate these rebates at period-end based on actual and estimated claims data and our estimates of the manufacturers' rebates earned by our clients. We base our estimates 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. We adjust our rebates payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. We record any cumulative effect of these adjustments against revenues as identified, and adjust our estimates prospectively to consider recurring matters. Adjustments generally result from contract changes with our clients or manufacturers, differences between the estimated and actual product mix subject to rebates or whether the product was included in the applicable formulary. We also deduct from our revenues pricing guarantees and guarantees regarding the level of service we will provide to the client or member as well as other payments made to our clients. Because the inputs to most of these estimates are not subject to a high degree of subjectivity or volatility, the effect of adjustments between estimated and actual amounts have not been material to our results of operations or financial position.

We participate in the Federal Government's Medicare Part D program as a PDP. Our net revenues include insurance premiums earned by the PDP, which are determined based on the PDP's annual bid and related contractual arrangements with CMS. The insurance premiums include a beneficiary premium, which is the responsibility of the PDP member, but is subsidized by CMS in the case of low-income members, and a direct premium paid by CMS. Premiums collected in advance are initially deferred as accrued expenses and are then recognized ratably as revenue over the period in which members are entitled to receive benefits.

In addition to these premiums, our net revenues include co-payments, coverage gap benefits, deductibles and co-insurance (collectively, the "Member Co-Payments") related to PDP members' actual prescription claims. In certain cases, CMS subsidizes a portion of these Member Co-Payments and we are paid an estimated prospective Member Co-Payment subsidy, each month. The prospective Member Co-Payment subsidy amounts received from CMS are also included in our net revenues. We assume no risk for these amounts, which represented 7.7%, 3.1% and 2.6% of consolidated net revenues in 2012, 2011 and 2010, respectively. If the prospective Member Co-Payment subsidies received differ from the amounts based on actual prescription claims, the difference is recorded in either accounts receivable or accrued expenses. We account for CMS obligations and Member Co-Payments (including the amounts subsidized by CMS) using the gross method consistent with our revenue recognition policies for Mail Co-Payments and Retail Co-Payments. We have recorded estimates of various assets and liabilities arising from our participation in the Medicare Part D program based on information in our claims management and enrollment systems. Significant estimates arising from our participation in the Medicare Part D program include: (i) estimates of low-income cost subsidy and reinsurance amounts ultimately payable to or receivable from CMS based on a detailed claims reconciliation, (ii) an estimate of amounts payable to CMS under a risk-sharing feature of the Medicare Part D program design, referred to as the risk corridor and (iii) estimates for claims that have been reported and are in the process of being paid or contested and for our estimate of claims that have been incurred but have not yet been reported. Actual amounts of Medicare Part D-related assets and liabilities could differ significantly from amounts recorded. Historically, the effect of these adjustments has not been material to our results of operations or financial position.

Retail Pharmacy Segment

Our Retail Pharmacy Segment recognizes revenue from the sale of merchandise (other than prescription drugs) at the time the merchandise is purchased by the retail customer. Revenue from the sale of prescription drugs is recognized at the time the prescription is filled as opposed to upon delivery as required under the Financial Accounting Standards Board ("FASB") Accounting Standards Codification 605, *Revenue Recognition*. For substantially all prescriptions, the fill date and the delivery date occur in the same reporting period. The effect on both revenue and income of recording prescription drug sales upon fill as opposed to delivery is immaterial. Customer returns are not material. Revenue generated from the performance of services in our health care clinics is recognized at the time the services are performed.

We have not made any material changes in the way we recognize revenue during the past three years.

Vendor Allowances and Purchase Discounts

Pharmacy Services Segment

Our Pharmacy Services Segment receives purchase discounts on products purchased. Contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for the Pharmacy Services Segment to receive purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These rebates are recognized when prescriptions

are dispensed and are generally calculated and billed to manufacturers within 30 days of the end of each completed quarter. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material to the results of operations. We account for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. The Pharmacy Services Segment also receives additional discounts under its wholesaler contract if it exceeds contractually defined annual purchase volumes. In addition, the Pharmacy Services Segment receives fees from pharmaceutical manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of "Cost of revenues".

Retail Pharmacy Segment

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

We have not made any material changes in the way we account for vendor allowances and purchase discounts during the past three years.

Inventory

Effective January 1, 2012, the Company changed its methods of accounting for prescription drug inventories in the Retail Pharmacy Segment. Prior to 2012, the Company valued prescription drug inventories at the lower of cost or market on a first-in, first-out ("FIFO") basis in retail pharmacies using the retail inventory method and in distribution centers using the FIFO cost method. Effective January 1, 2012, all prescription drug inventories in the Retail Pharmacy Segment have been valued at the lower of cost or market using the weighted average cost method. These changes affected approximately 51% of consolidated inventories.

These changes were made primarily to bring all of the pharmacy operations of the Company to a common inventory valuation methodology and to provide the Company with better information to manage its retail pharmacy operations. The Company believes the weighted average cost method is preferable to the retail inventory method and the FIFO cost method because it results in greater precision in the determination of cost of revenues and inventories by specific drug product and results in a consistent inventory valuation method for all of the Company's prescription drug inventories as the Pharmacy Services Segment's mail service and specialty pharmacies were already on the weighted average cost method. Most of these mail service and specialty pharmacies in the Pharmacy Services Segment were acquired in the Company's 2007 acquisition of Caremark Rx, Inc.

The Company recorded the cumulative effect of these changes in accounting principle as of January 1, 2012. The Company determined that retrospective application for periods prior to 2012 is impracticable, as the period-specific information necessary to value prescription drug inventories in the Retail Pharmacy Segment under the weighted average cost method is unavailable. The Company implemented a new pharmacy cost accounting system to value prescription drug inventory as of January 1, 2012 and calculated the cumulative impact. The effect of these changes in accounting principle as of January 1, 2012 was a decrease in inventories of $146 million, an increase in current deferred income tax assets of $57 million and a decrease in retained earnings of $89 million.

The weighted average cost method continues to be used to determine cost of sales and inventory in our mail service and specialty pharmacies in our Pharmacy Services Segment. Front store inventory in our Retail Pharmacy Segment is stated at the lower of cost or market on a FIFO basis using the retail method of accounting to determine cost of sales and inventory, and the cost method of accounting on a FIFO basis to determine front store inventory in our distribution centers. Under the retail method, inventory is stated at cost, which is determined by applying a cost-to-retail ratio to the ending retail value of our inventory. Since the retail value of our inventory is adjusted on a regular basis to reflect current market conditions, our carrying value should approximate the lower of cost or market. In addition, we reduce the value of our ending inventory for estimated inventory losses that have occurred during the interim period between physical inventory counts. Physical inventory counts are taken on a regular basis in each store and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the accompanying consolidated financial statements are properly stated. The accounting for inventory contains uncertainty since we must use judgment to estimate the inventory losses that have occurred during the interim period between physical inventory counts. When estimating these losses, we consider a number of factors, which include, but are not limited to, historical physical inventory results on a location-by-location basis and current physical inventory loss trends.

Our total reserve for estimated inventory losses covered by this critical accounting policy was $207 million as of December 31, 2012. Although we believe we have sufficient current and historical information available to us to record reasonable estimates for estimated inventory losses, it is possible that actual results could differ. In order to help you assess the aggregate risk, if any, associated with the uncertainties discussed above, a ten percent (10%) pre-tax change in our estimated inventory losses, which we believe is a reasonably likely change, would increase or decrease our total reserve for estimated inventory losses by about $21 million as of December 31, 2012.

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

Goodwill and Intangible Assets

Identifiable intangible assets consist primarily of trademarks, client contracts and relationships, favorable leases and covenants not to compete. 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. Goodwill represents the excess of amounts paid for acquisitions over the fair value of the net identifiable assets acquired.

We evaluate the recoverability of certain long-lived assets, including intangible assets with finite lives, but excluding goodwill and intangible assets with indefinite lives which are tested for impairment using separate tests, whenever events or changes in circumstances indicate that the carrying value of an asset may not be recoverable. We group and evaluate these long-lived assets for impairment at the lowest level at which individual cash flows can be identified. When evaluating these long-lived assets for potential impairment, we first compare the carrying amount of the asset group to the asset group's estimated future cash flows (undiscounted and without interest charges). If the estimated future cash flows are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group's estimated future cash flows (discounted and with interest charges). If required, an impairment loss is recorded for the portion of the asset group's carrying value that exceeds the asset group's estimated future cash flows (discounted and with interest charges). Our long-lived asset impairment loss calculation contains uncertainty since we must use judgment to estimate each asset group's future sales, profitability and cash flows. When preparing these estimates, we consider historical results and current operating trends and our consolidated sales, profitability and cash flow results and forecasts.

These estimates can be affected by a number of factors including, but not limited to, general economic and regulatory conditions, efforts of third party organizations to reduce their prescription drug costs and/or increased member co-payments, the continued efforts of competitors to gain market share and consumer spending patterns.

Goodwill and indefinitely-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable.

Indefinitely-lived intangible assets are tested by comparing the estimated fair value of the asset to its carrying value. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized and the asset is written down to its estimated fair value.

Our indefinitely-lived intangible asset impairment loss calculation contains uncertainty since we must use judgment to estimate the 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. Value is estimated by discounting the hypothetical royalty payments to their present value over the estimated economic life of the asset. These estimates can be affected by a number of factors including, but not limited to, general economic conditions, availability of market information as well as the profitability of the Company.

Goodwill is tested for impairment on a reporting unit basis using a two-step process. The first step of the impairment test is to identify potential impairment by comparing the reporting unit's fair value with its net book value (or carrying amount), including goodwill. The fair value of our reporting units is estimated using a combination of the discounted cash flow valuation model and comparable market transaction models. If the fair value of the reporting unit exceeds its carrying amount, the reporting unit's goodwill is not considered to be impaired and the second step of the impairment test is not performed. If the carrying amount of the reporting unit exceeds its fair value, the second step of the impairment test is performed to measure the amount of impairment loss, if any. The second step of the impairment test compares the implied fair value of the reporting unit's goodwill with the carrying amount of the goodwill. If the carrying amount of the reporting unit's goodwill exceeds the implied fair value of the goodwill, an impairment loss is recognized in an amount equal to that excess.

The determination of the fair value of our reporting units requires the Company to make significant assumptions and estimates. These assumptions and estimates primarily include, but are not limited to, the selection of appropriate peer group companies; control premiums and valuation multiples appropriate for acquisitions in the industries in which the Company competes; discount rates,

terminal growth rates; and forecasts of revenue, operating profit, depreciation and amortization, capital expenditures and future working capital requirements. When determining these assumptions and preparing these estimates, we consider each reporting unit's historical results and current operating trends and our consolidated revenues, profitability and cash flow results and forecasts. Our estimates can be affected by a number of factors including, but not limited to, general economic and regulatory conditions, our market capitalization, 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.

The carrying value of goodwill and other intangible assets covered by this critical accounting policy was $26.4 billion and $9.8 billion as of December 31, 2012, respectively. We did not record any impairment losses related to goodwill or other intangible assets during 2012, 2011 or 2010. During the third quarter of 2012, we performed our required annual impairment tests of goodwill and indefinitely-lived trademarks. The results of the impairment tests concluded that there was no impairment of goodwill or trademarks. The goodwill impairment test resulted in the fair value of our Pharmacy Services and Retail Pharmacy reporting units exceeding their carrying values by a significant margin. The carrying value of goodwill as of December 31, 2012, in our Pharmacy Services and Retail Pharmacy reporting units was $19.6 billion and $6.7 billion, respectively.

Although we believe we have sufficient current and historical information available to us to test for impairment, it is possible that actual results could differ from the estimates used in our impairment tests.

We have not made any material changes in the methodologies utilized to test the carrying values of goodwill and intangible assets for impairment during the past three years.

Closed Store Lease Liability

We account for closed store lease termination costs when a leased store is closed. When a leased store is closed, we record a liability for the estimated present value of the remaining obligation under the noncancelable lease, which includes future real estate taxes, common area maintenance and other charges, if applicable. The liability is reduced by estimated future sublease income.

The initial calculation and subsequent evaluations of our closed store lease liability contain uncertainty since we must use judgment to estimate the timing and duration of future vacancy periods, the amount and timing of future lump sum settlement payments and the amount and timing of potential future sublease income. When estimating these potential termination costs and their related timing, we consider a number of factors, which include, but are not limited to, historical settlement experience, the owner of the property, the location and condition of the property, the terms of the underlying lease, the specific marketplace demand and general economic conditions.

Our total closed store lease liability covered by this critical accounting policy was $339 million as of December 31, 2012. This amount is net of $209 million of estimated sublease income that is subject to the uncertainties discussed above. Although we believe we have sufficient current and historical information available to us to record reasonable estimates for sublease income, it is possible that actual results could differ.

In order to help you assess the risk, if any, associated with the uncertainties discussed above, a ten percent (10%) pre-tax change in our estimated sublease income, which we believe is a reasonably likely change, would increase or decrease our total closed store lease liability by about $21 million as of December 31, 2012.

We have not made any material changes in the reserve methodology used to record closed store lease reserves during the past three years.

Self-Insurance Liabilities

We are self-insured for certain losses related to general liability, workers' compensation and auto liability, although we maintain stop loss coverage with third party insurers to limit our total liability exposure. We are also self-insured for certain losses related to health and medical liabilities.

The estimate of our self-insurance liability contains uncertainty since we must use judgment to estimate the ultimate cost that will be incurred to settle reported claims and unreported claims for incidents incurred but not reported as of the balance sheet date. When estimating our self-insurance liability, we consider a number of factors, which include, but are not limited to, historical claim experience, demographic factors, severity factors and other standard insurance industry actuarial assumptions. On a quarterly basis, we review our self-insurance liability to determine if it is adequate as it relates to our general liability, workers' compensation and auto liability. Similar reviews are conducted semi-annually to determine if our self-insurance liability is adequate for our health and medical liability.

Our total self-insurance liability covered by this critical accounting policy was $590 million as of December 31, 2012. Although we believe we have sufficient current and historical information available to us to record reasonable estimates for our self-insurance

liability, it is possible that actual results could differ. In order to help you assess the risk, if any, associated with the uncertainties discussed above, a ten percent (10%) pre-tax change in our estimate for our self-insurance liability, which we believe is a reasonably likely change, would increase or decrease our self-insurance liability by about $59 million as of December 31, 2012.

We have not made any material changes in the accounting methodology used to establish our self-insurance liability during the past three years.

New Accounting Pronouncements

In June 2011, the FASB issued ASU 2011-05, *Presentation of Comprehensive Income* ("ASU 2011-05"). ASU 2011-05 eliminates the current option to report other comprehensive income and its components in the statement of shareholders' equity. Instead, an entity will have the option to present the total of comprehensive income, the components of net income, and the components of other comprehensive income either in a single continuous statement of comprehensive income or in two separate but consecutive statements. ASU 2011-05 also required entities to present reclassification adjustments out of accumulated other comprehensive income by component in both the statement in which net income is presented and the statement in which other comprehensive income is presented. In December 2011, the FASB issued ASU 2011-12 *Deferral of the Effective Date for Amendments to the Presentation of Reclassification of Items Out of Accumulated Other Comprehensive Income in Accounting Standards Update No. 2011-05*, which indefinitely defers the guidance related to the presentation of reclassification adjustments. ASU 2011-05 is effective for interim and annual periods beginning after December 15, 2011 and should be applied retrospectively. The Company elected to report other comprehensive income and its components in a separate statement of comprehensive income beginning in the first quarter of 2012. The adoption of ASU 2011-05 did not have a material effect on the Company's consolidated financial statements.

In September 2011, the FASB issued ASU 2011-08, *Testing Goodwill for Impairment* ("ASU 2011-08"). ASU 2011-08 allows entities to use a qualitative approach to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying value. If after performing the qualitative assessment an entity determines it is not more likely than not that the fair value of a reporting unit is less than its carrying amount, then performing the two-step goodwill impairment test is unnecessary. However, if an entity concludes otherwise, then it is required to perform the first step of the two-step goodwill impairment test. ASU 2011-08 is effective for annual and interim goodwill impairment tests performed for fiscal years beginning after December 15, 2011. The adoption of ASU 2011-08 did not have a material effect on the Company's consolidated financial statements. The Company did not elect to use the qualitative approach in its 2012 annual goodwill impairment test.

In July 2012, the FASB issued ASU 2012-02, *Testing Indefinite-Lived Intangible Assets for Impairment* ("ASU 2012-02"). ASU 2012-02 allows entities to use a qualitative approach to determine whether the existence of events and circumstances indicates that it is more likely than not that the indefinite-lived intangible asset is impaired. If, after assessing the totality of events and circumstances, an entity concludes that it is not more likely than not that the indefinite-lived intangible asset is impaired, then the entity is not required to take further action. However, if an entity concludes otherwise, then it is required to determine the fair value of the indefinite-lived intangible asset and perform the quantitative impairment test by comparing the fair value with the carrying amount and recognize an impairment loss, if any, to the extent the carrying value exceeds its fair value. ASU 2012-02 is effective for annual and interim impairment tests performed for fiscal years beginning after September 15, 2012, and early adoption is permitted. The Company did not elect to early adopt ASU 2012-02 and does not expect the adoption will have a material effect on the Company's consolidated financial statements.

Cautionary Statement Concerning Forward-Looking Statements

The Private Securities Litigation Reform Act of 1995 (the "Reform Act") provides a safe harbor for forward-looking statements made by or on behalf of CVS Caremark Corporation. The Company and its representatives may, from time to time, make written or verbal forward-looking statements, including statements contained in the Company's filings with the Securities and Exchange Commission ("SEC") and in its reports to stockholders. Generally, the inclusion of the words "believe," "expect," "intend," "estimate," "project," "anticipate," "will," "should" and similar expressions identify statements that constitute forward-looking statements. All statements addressing operating performance of CVS Caremark Corporation or any subsidiary, events or developments that the Company expects or anticipates will occur in the future, including statements relating to revenue growth, earnings or earnings per common share growth, adjusted earnings or adjusted earnings per common share growth, free cash flow, debt ratings, inventory levels, inventory turn and loss rates, store development, relocations and new market entries, PBM business and sales trends, the Company's ability to attract or retain customers, Medicare Part D competitive bidding and enrollment, new product development and the impact of industry 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.

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

By their nature, all forward-looking statements involve risks and uncertainties. Actual results may differ materially from those contemplated by the forward-looking statements for a number of reasons, including, but not limited to:

- *Risks relating to the health of the economy in general and in the markets we serve, which could impact consumer purchasing power, preferences and/or spending patterns, drug utilization trends, the financial health of our PBM clients or other payors doing business with the Company and our ability to secure necessary financing, suitable store locations and sale-leaseback transactions on acceptable terms.*

- *Efforts to reduce reimbursement levels and alter health care financing practices, including pressure to reduce reimbursement levels for generic drugs.*

- *The possibility of PBM client loss and/or the failure to win new PBM business.*

- *Risks related to the frequency and rate of the introduction of generic drugs and brand name prescription products.*

- *Risks of declining gross margins in the PBM industry attributable to increased competitive pressures, increased client demand for lower prices, enhanced service offerings and/or higher service levels and market dynamics and regulatory changes that impact our ability to offer plan sponsors pricing that includes the use of retail "differential" or "spread."*

- *Regulatory changes, business changes and compliance requirements relating to our participation in Medicare, Medicaid and other federal and state government-funded programs, including requirements and restrictions imposed by CMS and other government agencies, as applicable, relating to our participation in the Medicare Part D program and other government-funded programs.*

- *Possible changes in industry pricing benchmarks used to establish pricing in many of our PBM client contracts, pharmaceutical purchasing arrangements, retail network contracts, specialty payor agreements and other third party payor contracts.*

- *An extremely competitive business environment, including the uncertain impact of increased consolidation in the PBM industry, uncertainty concerning the ability of our retail pharmacy business to secure and maintain contractual relationships with PBMs and other payors on acceptable terms, uncertainty concerning the ability of our PBM business to secure and maintain competitive access, pricing and other contract terms from retail network pharmacies in an environment where some PBM clients are willing to consider adopting narrow or more restricted retail pharmacy networks.*

- *Uncertainty relating to the effect on our net revenues, gross profit, marketing and other operating expenses and cash flows over time if we are unable to retain the business we have gained as a result of the Express Scripts and Walgreens contractual impasse to the extent anticipated.*

- *Risks relating to our ability to secure timely and sufficient access to the products we sell from our domestic and/or international suppliers.*

- *Reform of the U.S. health care system, including ongoing implementation of the Patient Protection and Affordable Care Act, continuing legislative efforts, regulatory changes and judicial interpretations impacting our health care system and the possibility of shifting political and legislative priorities related to reform of the health care system in the future.*

- *Risks relating to our failure to properly maintain our information technology systems, our information security systems and our infrastructure to support our business and to protect the privacy and security of sensitive customer and business information.*

- *Risks related to compliance with a broad and complex regulatory framework, including compliance with new and existing federal, state and local laws and regulations relating to health care, accounting standards, corporate securities, tax, environmental and other laws and regulations affecting our business.*

- *Risks related to litigation, government investigations and other legal proceedings as they relate to our business, the pharmacy services, retail pharmacy or retail clinic industries or to the health care industry generally.*

- *Other risks and uncertainties detailed from time to time in our filings with the SEC.*

The foregoing list is not exhaustive. There can be no assurance that the Company has correctly identified and appropriately assessed all factors affecting its business. Additional risks and uncertainties not presently known to the Company or that it currently believes to be immaterial also may adversely impact the Company. Should any risks and uncertainties develop into actual events, these developments could have a material adverse effect on the Company's business, financial condition and results of operations. For these reasons, you are cautioned not to place undue reliance on the Company's forward-looking statements.

Management's Report on Internal Control Over Financial Reporting

We are responsible for establishing and maintaining adequate internal control over financial reporting. Our Company's internal control over financial reporting includes those policies and procedures that pertain to the Company's ability to record, process, summarize and report a system of internal accounting controls and procedures to provide reasonable assurance, at an appropriate cost/benefit relationship, that the unauthorized acquisition, use or disposition of assets are prevented or timely detected and that transactions are authorized, recorded and reported properly to permit the preparation of financial statements in accordance with generally accepted accounting principles (GAAP) and receipt and expenditures are duly authorized. In order to ensure the Company's internal control over financial reporting is effective, management regularly assesses such controls and did so most recently for its financial reporting as of December 31, 2012.

We conducted an assessment of the effectiveness of our internal controls over financial reporting based on the criteria set forth in *Internal Control-Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. This evaluation included review of the documentation, evaluation of the design effectiveness and testing of the operating effectiveness of controls. Our system of internal control over financial reporting is enhanced by periodic reviews by our internal auditors, written policies and procedures and a written Code of Conduct adopted by our Company's Board of Directors, applicable to all employees of our Company. In addition, we have an internal Disclosure Committee, comprised of management from each functional area within the Company, which performs a separate review of our disclosure controls and procedures. There are inherent limitations in the effectiveness of any system of internal controls over financial reporting.

Based on our assessment, we conclude our 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, 2012.

Ernst & Young LLP, independent registered public accounting firm, is appointed by the Board of Directors and ratified by our Company's shareholders. They were engaged to render an opinion regarding the fair presentation of our consolidated financial statements as well as conducting an audit of internal control over financial reporting. Their accompanying reports are based upon an audit conducted in accordance with the standards of the Public Company Accounting Oversight Board (United States).

February 15, 2013

Report of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders of CVS Caremark Corporation

We have audited CVS Caremark Corporation's internal control over financial reporting as of December 31, 2012, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (the COSO criteria). CVS Caremark Corporation'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 CVS Caremark Corporation's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). 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.

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.

In our opinion, CVS Caremark Corporation maintained, in all material respects, effective internal control over financial reporting as of December 31, 2012, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of CVS Caremark Corporation as of December 31, 2012 and 2011, and the related consolidated statements of income, comprehensive income, shareholders' equity and cash flows for each of the three years in the period ended December 31, 2012 of CVS Caremark Corporation and our report dated February 15, 2013 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Boston, Massachusetts
February 15, 2013

Consolidated Statements of Income

In millions, except per share amounts	Year Ended December 31, 2012	2011	2010
Net revenues	$ 123,133	$ 107,100	$95,778
Cost of revenues	100,627	86,539	75,559
Gross profit	22,506	20,561	20,219
Operating expenses	15,278	14,231	14,082
Operating profit	7,228	6,330	6,137
Interest expense, net	557	584	536
Loss on early extinguishment of debt	348	—	—
Income before income tax provision	6,323	5,746	5,601
Income tax provision	2,441	2,258	2,179
Income from continuing operations	3,882	3,488	3,422
Income (loss) from discontinued operations, net of tax	(7)	(31)	2
Net income	3,875	3,457	3,424
Net loss attributable to noncontrolling interest	2	4	3
Net income attributable to CVS Caremark	$ 3,877	$ 3,461	$ 3,427
Basic earnings per common share:			
Income from continuing operations attributable to CVS Caremark	$ 3.06	$ 2.61	$ 2.51
Income (loss) from discontinued operations attributable to CVS Caremark	(0.01)	(0.02)	—
Net income attributable to CVS Caremark	$ 3.05	$ 2.59	$ 2.51
Weighted average common shares outstanding	1,271	1,338	1,367
Diluted earnings per common share:			
Income from continuing operations attributable to CVS Caremark	$ 3.03	$ 2.59	$ 2.49
Income (loss) from discontinued operations attributable to CVS Caremark	(0.01)	(0.02)	—
Net income attributable to CVS Caremark	$ 3.03	$ 2.57	$ 2.49
Weighted average common shares outstanding	1,280	1,347	1,377
Dividends declared per common share	$ 0.65	$ 0.50	$ 0.35

See accompanying notes to consolidated financial statements.

Consolidated Statements of Comprehensive Income

In millions	Year Ended December 31, 2012	2011	2010
Net income	$ 3,875	$ 3,457	$ 3,424
Other comprehensive income (loss):			
Net cash flow hedges, net of income tax	3	(9)	(1)
Pension liability adjustment, net of income tax	(12)	(20)	(7)
Comprehensive income	3,866	3,428	3,416
Comprehensive loss attributable to noncontrolling interest	2	4	3
Comprehensive income attributable to CVS Caremark	$ 3,868	$ 3,432	$ 3,419

See accompanying notes to consolidated financial statements.

Consolidated Balance Sheets

In millions, except per share amounts	December 31, 2012	December 31, 2011
Assets:		
Cash and cash equivalents	$ 1,375	$ 1,413
Short-term investments	5	5
Accounts receivable, net	6,473	6,047
Inventories	10,759	10,046
Deferred income taxes	663	503
Other current assets	577	580
Total current assets	19,852	18,594
Property and equipment, net	8,632	8,467
Goodwill	26,395	26,458
Intangible assets, net	9,753	9,869
Other assets	1,280	1,155
Total assets	$65,912	$64,543
Liabilities:		
Accounts payable	$ 5,070	$ 4,370
Claims and discounts payable	3,974	3,487
Accrued expenses	4,051	3,293
Short-term debt	690	750
Current portion of long-term debt	5	56
Total current liabilities	13,790	11,956
Long-term debt	9,133	9,208
Deferred income taxes	3,784	3,853
Other long-term liabilities	1,501	1,445
Commitments and contingencies (Note 13)		
Redeemable noncontrolling interest	—	30
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; 1,667 shares issued and 1,231 shares outstanding at December 31, 2012 and 1,640 shares issued and 1,298 shares outstanding at December 31, 2011	17	16
Treasury stock, at cost: 435 shares at December 31, 2012 and 340 shares at December 31, 2011	(16,270)	(11,953)
Shares held in trust: 1 share at December 31, 2012 and 2 shares at December 31, 2011	(31)	(56)
Capital surplus	29,120	28,126
Retained earnings	25,049	22,090
Accumulated other comprehensive loss	(181)	(172)
Total shareholders' equity	37,704	38,051
Total liabilities and shareholders' equity	$65,912	$64,543

See accompanying notes to consolidated financial statements.

Consolidated Statements of Cash Flows

In millions	Year Ended December 31, 2012	2011	2010
Cash flows from operating activities:			
Cash receipts from customers	$113,205	$ 97,688	$ 94,503
Cash paid for inventory and prescriptions dispensed by retail network pharmacies	(90,032)	(75,148)	(73,143)
Cash paid to other suppliers and employees	(13,643)	(13,635)	(13,778)
Interest received	4	4	4
Interest paid	(581)	(647)	(583)
Income taxes paid	(2,282)	(2,406)	(2,224)
Net cash provided by operating activities	6,671	5,856	4,779
Cash flows from investing activities:			
Purchases of property and equipment	(2,030)	(1,872)	(2,005)
Proceeds from sale-leaseback transactions	529	592	507
Proceeds from sale of property and equipment	23	4	34
Acquisitions (net of cash acquired) and other investments	(378)	(1,441)	(177)
Purchase of available-for-sale investments	—	(3)	—
Maturity of available-for-sale investments	—	60	1
Proceeds from sale of subsidiary	7	250	—
Net cash used in investing activities	(1,849)	(2,410)	(1,640)
Cash flows from financing activities:			
Increase (decrease) in short-term debt	(60)	450	(15)
Proceeds from issuance of long-term debt	1,239	1,463	991
Repayments of long-term debt	(1,718)	(2,122)	(2,103)
Purchase of noncontrolling interest in subsidiary	(26)	—	—
Dividends paid	(829)	(674)	(479)
Derivative settlements	—	(19)	(5)
Proceeds from exercise of stock options	836	431	285
Excess tax benefits from stock-based compensation	28	21	28
Repurchase of common stock	(4,330)	(3,001)	(1,500)
Other	—	(9)	—
Net cash used in financing activities	(4,860)	(3,460)	(2,798)
Net increase (decrease) in cash and cash equivalents	(38)	(14)	341
Cash and cash equivalents at the beginning of the year	1,413	1,427	1,086
Cash and cash equivalents at the end of the year	$ 1,375	$ 1,413	$ 1,427
Reconciliation of net income to net cash provided by operating activities:			
Net income	$ 3,875	$ 3,457	$ 3,424
Adjustments required to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	1,753	1,568	1,469
Stock-based compensation	132	135	150
Loss on early extinguishment of debt	348	—	—
Gain on sale of subsidiary	—	(53)	—
Deferred income taxes and other noncash items	(106)	144	30
Change in operating assets and liabilities, net of effects from acquisitions:			
Accounts receivable, net	(387)	(748)	532
Inventories	(858)	607	(352)
Other current assets	3	(420)	(4)
Other assets	(99)	(49)	(210)
Accounts payable and claims and discounts payable	1,147	1,128	(40)
Accrued expenses	753	85	(176)
Other long-term liabilities	110	2	(44)
Net cash provided by operating activities	$ 6,671	$ 5,856	$ 4,779

See accompanying notes to consolidated financial statements.

Consolidated Statements of Shareholders' Equity

In millions	Shares Year Ended December 31, 2012	2011	2010	Dollars Year Ended December 31, 2012	2011	2010
Common stock:						
Beginning of year	1,640	1,624	1,612	$ 16	$ 16	$ 16
Stock options exercised and issuance of stock awards	27	16	12	1	—	—
End of year	1,667	1,640	1,624	$ 17	$ 16	$ 16
Treasury stock:						
Beginning of year	(340)	(259)	(219)	$(11,953)	$ (9,030)	$ (7,610)
Purchase of treasury shares	(95)	(84)	(42)	(4,330)	(3,001)	(1,500)
Employee stock purchase plan issuances	1	3	2	47	78	80
Transfer of shares from shares held in trust	(1)	—	—	(34)	—	—
End of year	(435)	(340)	(259)	$ (16,270)	$(11,953)	$ (9,030)
Shares held in trust:						
Beginning of year	(2)	(2)	(2)	$ (56)	$ (56)	$ (56)
Transfer of shares to treasury stock	1	—	—	25	—	—
End of year	(1)	(2)	(2)	$ (31)	$ (56)	$ (56)
Capital surplus:						
Beginning of year				$ 28,126	$27,610	$27,198
Stock option activity and stock awards				955	495	384
Tax benefit on stock options and stock awards				28	21	28
Transfer of shares held in trust to treasury stock				9	—	—
Purchase of noncontrolling interest in subsidiary				2	—	—
End of year				$ 29,120	$28,126	$27,610
Retained earnings:						
Beginning of year				$ 22,090	$19,303	$16,355
Changes in inventory accounting principles (Note 2)				(89)	—	—
Net income attributable to CVS Caremark				3,877	3,461	3,427
Common stock dividends				(829)	(674)	(479)
End of year				$ 25,049	$22,090	$19,303
Accumulated other comprehensive loss:						
Beginning of year				$ (172)	$ (143)	$ (135)
Net cash flow hedges, net of income tax				3	(9)	(1)
Pension liability adjustment, net of income tax				(12)	(20)	(7)
End of year				$ (181)	$ (172)	$ (143)
Total shareholders' equity				$ 37,704	$38,051	$37,700

See accompanying notes to consolidated financial statements.

Notes to Consolidated Financial Statements

1 Significant Accounting Policies

Description of business - CVS Caremark Corporation and its subsidiaries (the "Company") is the largest integrated pharmacy health care provider in the United States based upon revenues and prescriptions filled. The Company currently has three reportable business segments, Pharmacy Services, Retail Pharmacy and Corporate, which are described below.

Pharmacy Services Segment (the "PSS") - The PSS provides a full range of pharmacy benefit management services including mail order pharmacy services, specialty pharmacy services, plan design and administration, formulary management and claims processing. The Company's clients are primarily employers, insurance companies, unions, government employee groups, managed care organizations and other sponsors of health benefit plans and individuals throughout the United States.

As a pharmacy benefits manager, the PSS manages the dispensing of pharmaceuticals through the Company's mail order pharmacies and national network of approximately 67,000 retail pharmacies to eligible members in the benefits plans maintained by the Company's clients and utilizes its information systems to perform, among other things, safety checks, drug interaction screenings and brand to generic substitutions.

The PSS' specialty pharmacies support individuals that require complex and expensive drug therapies. The specialty pharmacy business includes mail order and retail specialty pharmacies that operate under the CVS Caremark® and CarePlus CVS/pharmacy® names.

The PSS also provides health management programs, which include integrated disease management for 17 conditions, through the Company's Accordant® health management offering.

In addition, through the Company's SilverScript Insurance Company ("SilverScript") and Pennsylvania Life Insurance Company ("Pennsylvania Life") subsidiaries, the PSS is a national provider of drug benefits to eligible beneficiaries under the Federal Government's Medicare Part D program.

The PSS generates net revenues primarily by contracting with clients to provide prescription drugs to plan members. Prescription drugs are dispensed by the mail order pharmacies, specialty pharmacies and national network of retail pharmacies. Net revenues are also generated by providing additional services to clients, including administrative services such as claims processing and formulary management, as well as health care related services such as disease management.

The pharmacy services business operates under the CVS Caremark® Pharmacy Services, Caremark®, CVS Caremark®, CarePlus CVS/pharmacy®, RxAmerica® and Accordant® names. As of December 31, 2012, the PSS operated 31 retail specialty pharmacy stores, 12 specialty mail order pharmacies and five mail service pharmacies located in 22 states, Puerto Rico and the District of Columbia.

Retail Pharmacy Segment (the "RPS") - The RPS sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products and cosmetics, photo finishing, seasonal merchandise, greeting cards and convenience foods, through the Company's CVS/pharmacy® and Longs Drugs® retail stores and online through CVS.com®.

The RPS also provides health care services through its MinuteClinic® health care clinics. MinuteClinics are staffed by nurse practitioners and physician assistants who utilize nationally recognized protocols to diagnose and treat minor health conditions, perform health screenings, monitor chronic conditions and deliver vaccinations.

As of December 31, 2012, the retail pharmacy business included 7,458 retail drugstores (of which 7,402 operated a pharmacy) located in 42 states, the District of Columbia and Puerto Rico operating primarily under the CVS/pharmacy® name, the online retail website, CVS.com, and 640 retail health care clinics operating under the MinuteClinic® name (of which 633 were located in CVS/pharmacy stores).

Corporate Segment - The Corporate Segment provides management and administrative services to support the Company. The Corporate Segment consists of certain aspects of the Company's executive management, corporate relations, legal, compliance, human resources, corporate information technology and finance departments.

Principles of consolidation - The consolidated financial statements include the accounts of the Company and its majority owned subsidiaries. All intercompany balances and transactions have been eliminated.

Use of estimates - The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America 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.

Fair value hierarchy - The Company utilizes the three-level valuation hierarchy for the recognition and disclosure of fair value measurements. The categorization of assets and liabilities within this hierarchy is based upon the lowest level of input that is significant to the measurement of fair value. The three levels of the hierarchy consist of the following:

- Level 1 - Inputs to the valuation methodology are unadjusted quoted prices in active markets for identical assets or liabilities that the Company has the ability to access at the measurement date.
- Level 2 - Inputs to the valuation methodology are quoted prices for similar assets and liabilities in active markets, quoted prices in markets that are not active or inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the instrument.
- Level 3 - Inputs to the valuation methodology are unobservable inputs based upon management's best estimate of inputs market participants could use in pricing the asset or liability at the measurement date, including assumptions about risk.

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. These investments are classified within Level 1 of the fair value hierarchy because they are valued using quoted market prices.

Short-term investments - The Company's short-term investments consist of certificate of deposits with initial maturities of greater than three months when purchased. These investments, which were classified as available-for-sale within Level 1 of the fair value hierarchy, were carried at historical cost, which approximated fair value at December 31, 2012 and 2011.

Fair value of financial instruments - As of December 31, 2012, the Company's financial instruments include cash and cash equivalents, short-term investments, accounts receivable, accounts payable and short-term debt. Due to the short-term nature of these instruments, the Company's carrying value approximates fair value. The carrying amount and estimated fair value of total long-term debt was $9.1 billion and $10.8 billion, respectively, as of December 31, 2012. The fair value of the Company's long-term debt was estimated based on quoted rates currently offered in active markets for the Company's debt, which is considered Level 1 of the fair value hierarchy. The Company had outstanding letters of credit, which guaranteed foreign trade purchases, with a fair value of $4.9 million as of December 31, 2012. There were no outstanding derivative financial instruments as of December 31, 2012 and 2011.

Accounts receivable - Accounts receivable are stated net of an allowance for doubtful accounts. The accounts receivable balance primarily includes trade amounts due from third party providers (e.g., pharmacy benefit managers, insurance companies and governmental agencies), clients and members, as well as vendors and manufacturers.

The activity in the allowance for doubtful trade accounts receivable is as follows:

	Year Ended December 31,		
In millions	**2012**	**2011**	**2010**
Beginning balance	$ 189	$ 182	$224
Additions charged to bad debt expense	149	129	73
Write-offs charged to allowance	(95)	(122)	(115)
Ending balance	$ 243	$ 189	$182

Inventories - Prior to 2012, inventories were stated at the lower of cost or market on a first-in, first-out basis using the retail inventory method in the retail pharmacy stores, the weighted average cost method in the mail service and specialty pharmacies, and the cost method on a first-in, first-out basis in the distribution centers. Effective January 1, 2012, the Company changed its methods of accounting for prescription drug inventories in the RPS to the weighted average cost method. See Note 2 for additional information regarding the accounting change. Physical inventory counts are taken on a regular basis in each store and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the accompanying consolidated financial statements are properly stated. During the interim period between physical inventory counts, the Company accrues for anticipated physical inventory losses on a location-by-location basis based on historical results and current trends.

Property and equipment - 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 10 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.

The following are the components of property and equipment at December 31:

In millions	**2012**	**2011**
Land	$ 1,429	$ 1,295
Building and improvements	2,614	2,404
Fixtures and equipment	7,928	7,582
Leasehold improvements	3,105	3,021
Software	1,230	1,098
	16,306	15,400
Accumulated depreciation and amortization	(7,674)	(6,933)
	$ 8,632	$ 8,467

The gross amount of property and equipment under capital leases was $219 million and $211 million as of December 31, 2012 and 2011, respectively. Amortization of property and equipment under capital lease is included within depreciation expense. Depreciation expense totaled $1.3 billion, $1.1 billion and $1.0 billion in 2012, 2011 and 2010, respectively.

Goodwill and other indefinitely-lived assets - Goodwill and other indefinitely-lived assets are not amortized, but are subject to impairment reviews annually, or more frequently if necessary. See Note 5 for additional information on goodwill and other indefinitely-lived assets.

Intangible assets - Purchased customer contracts and relationships are amortized on a straight-line basis over their estimated useful lives between 10 and 20 years. Purchased customer lists are amortized on a straight-line basis over their estimated useful lives of up to 10 years. Purchased leases are amortized on a straight-line basis over the remaining life of the lease. See Note 5 for additional information about intangible assets.

Impairment of long-lived assets - The Company groups and evaluates fixed and finite-lived intangible assets for impairment at the lowest level at which individual cash flows can be identified, whenever events or changes in circumstances indicate that the carrying value of an asset may not be recoverable. If indicators of impairment are present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted and without interest charges). If the estimated future cash flows used in this analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group’s estimated future cash flows (discounted and with interest charges). If required, an impairment loss is recorded for the portion of the asset group’s carrying value that exceeds the asset group’s estimated future cash flows (discounted and with interest charges).

Redeemable noncontrolling interest – Through June 29, 2012, the Company had an approximately 60% ownership interest in Generation Health, Inc. ("Generation Health") and consolidated Generation Health in its consolidated financial statements. The nonemployee noncontrolling shareholders of Generation Health held put rights for the remaining interest in Generation Health that if exercised would require the Company to purchase the remaining interest in Generation Health in 2015 for a minimum of $26 million and a maximum of $159 million, depending on certain financial metrics of Generation Health in 2014. Since the noncontrolling shareholders of Generation Health had a redemption feature as a result of the put rights, the Company had classified the redeemable noncontrolling interest in Generation Health in the mezzanine section of the consolidated balance sheet outside of shareholders' equity. On June 29, 2012, the Company acquired the remaining 40% interest in Generation Health from minority shareholders and employee option holders for $26 million and $5 million, respectively, for a total of $31 million.

The following is a reconciliation of the changes in the redeemable noncontrolling interest:

In millions	2012	2011	2010
Beginning balance	$ 30	$ 34	$ 37
Net loss attributable to noncontrolling interest	(2)	(4)	(3)
Purchase of noncontrolling interest	(26)	—	—
Reclassification to capital surplus in connection with purchase of noncontrolling interest	(2)	—	—
Ending balance	$ —	$ 30	$ 34

Revenue Recognition

Pharmacy Services Segment - The PSS sells prescription drugs directly through its mail service pharmacies and indirectly through its retail pharmacy network. The PSS recognizes revenue from prescription drugs sold by its mail service pharmacies and under retail pharmacy network contracts where it is the principal using the gross method at the contract prices negotiated with its clients. Net revenues include: (i) the portion of the price the client pays directly to the PSS, net of any volume-related or other discounts paid back to the client (see "Drug Discounts" below), (ii) the price paid to the PSS by client plan members for mail order prescriptions ("Mail Co-Payments") and the price paid to retail network pharmacies by client plan members for retail prescriptions ("Retail Co-Payments"), and (iii) administrative fees for retail pharmacy network contracts where the PSS is not the principal as discussed below.

Revenue is recognized when: (i) persuasive evidence of an arrangement exists, (ii) delivery has occurred or services have been rendered, (iii) the seller's price to the buyer is fixed or determinable, and (iv) collectability is reasonably assured. The following revenue recognition policies have been established for the PSS:

- Revenues generated from prescription drugs sold by mail service pharmacies are recognized when the prescription is shipped. At the time of shipment, the PSS has performed substantially all of its obligations under its client contracts and does not experience a significant level of returns or reshipments.

- Revenues generated from prescription drugs sold by third party pharmacies in the PSS's retail pharmacy network and associated administrative fees are recognized at the PSS's point-of-sale, which is when the claim is adjudicated by the PSS's online claims processing system.

The PSS determines whether it is the principal or agent for its retail pharmacy network transactions on a contract by contract basis. In the majority of its contracts, the PSS has determined it is the principal due to it: (i) being the primary obligor in the arrangement, (ii) having latitude in establishing the price, changing the product or performing part of the service, (iii) having discretion in supplier selection, (iv) having involvement in the determination of product or service specifications, and (v) having credit risk. The PSS's obligations under its client contracts for which revenues are reported using the gross method are separate and distinct from its obligations to the third party pharmacies included in its retail pharmacy network contracts. Pursuant to these contracts, the PSS is contractually required to pay the third party pharmacies in its retail pharmacy network for products sold, regardless of whether the PSS is paid by its clients. The PSS's responsibilities under its client contracts typically include validating eligibility and coverage levels, communicating the prescription price and the co-payments due to the third party retail pharmacy, identifying possible adverse drug interactions for the pharmacist to address with the prescriber prior to dispensing, suggesting clinically appropriate generic alternatives where appropriate and approving the prescription for dispensing. Although the PSS does not have credit risk with respect to Retail Co-Payments, management believes that all of the other indicators of gross revenue reporting are present. For contracts under which the PSS acts as an agent, revenue is recognized using the net method.

Drug Discounts - The PSS deducts from its revenues any rebates, inclusive of discounts and fees, earned by its clients. Rebates are paid to clients in accordance with the terms of client contracts, which are normally based on fixed rebates per prescription for specific products dispensed or a percentage of manufacturer discounts received for specific products dispensed. The liability for rebates due to clients is included in "Claims and discounts payable" in the accompanying consolidated balance sheets.

Medicare Part D - The PSS participates in the Federal Government's Medicare Part D program as a Prescription Drug Plan ("PDP"). Net revenues include insurance premiums earned by the PDP, which are determined based on the PDP's annual bid and related contractual arrangements with the Centers for Medicare and Medicaid Services ("CMS"). The insurance premiums include a direct premium paid by CMS and a beneficiary premium, which is the responsibility of the PDP member, but is subsidized by CMS in the case of low-income members. Premiums collected in advance are initially deferred in accrued expenses and are then recognized in net revenues over the period in which members are entitled to receive benefits.

In addition to these premiums, net revenues include co-payments, coverage gap benefits, deductibles and co-insurance (collectively, the "Member Co-Payments") related to PDP members' actual prescription claims. In certain cases, CMS subsidizes a portion of these Member Co-Payments and pays the PSS an estimated prospective Member Co-Payment subsidy amount each month. The prospective Member Co-Payment subsidy amounts received from CMS are also included in net revenues. The Company assumes no risk for these amounts. If the prospective Member Co-Payment subsidies received differ from the amounts based on actual prescription claims, the difference is recorded in either accounts receivable or accrued expenses.

The PSS accounts for CMS obligations and Member Co-Payments (including the amounts subsidized by CMS) using the gross method consistent with its revenue recognition policies for Mail Co-Payments and Retail Co-Payments (discussed previously in this document).

Retail Pharmacy Segment - The RPS recognizes revenue from the sale of merchandise (other than prescription drugs) at the time the merchandise is purchased by the retail customer. Revenue from the sale of prescription drugs is recognized at the time the prescription is filled as opposed to upon delivery as required under the Financial Accounting Standards Board ("FASB") Accounting Standards Codification 605, *Revenue Recognition*. For substantially all prescriptions, the fill date and the delivery date occur in the same reporting period. The effect on both revenue and income of recording prescription drug sales upon fill as opposed to delivery is immaterial. Customer returns are not material. Revenue generated from the performance of services in the RPS's health care clinics is recognized at the time the services are performed.

See Note 14 for additional information about the revenues of the Company's business segments.

Cost of revenues

Pharmacy Services Segment - The PSS' cost of revenues includes: (i) the cost of prescription drugs sold during the reporting period directly through its mail service pharmacies and indirectly through its retail pharmacy network, (ii) shipping and handling costs, and (iii) the operating costs of its mail service pharmacies and client service operations and related information technology support costs including depreciation and amortization. The cost of prescription drugs sold component of cost of revenues includes: (i) the cost of the prescription drugs purchased from manufacturers or distributors and shipped to members in clients' benefit plans from the PSS' mail service pharmacies, net of any volume-related or other discounts (see "Drug Discounts" previously in this document) and (ii) the cost of prescription drugs sold (including Retail Co-Payments) through the PSS' retail pharmacy network under contracts where it is the principal, net of any volume-related or other discounts.

Retail Pharmacy Segment - The RPS' cost of revenues includes: the cost of merchandise sold during the reporting period and the related purchasing costs, warehousing and delivery costs (including depreciation and amortization) and actual and estimated inventory losses. See Note 14 for additional information about the cost of revenues of the Company's business segments.

Vendor allowances and purchase discounts

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

Pharmacy Services Segment - The PSS receives purchase discounts on products purchased. The PSS' contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for the PSS to receive purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices, or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These rebates are recognized when prescriptions are dispensed and are generally calculated and billed to manufacturers within 30 days 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 PSS' results of operations. The PSS accounts for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. The PSS also receives additional discounts under its wholesaler contract if it exceeds contractually defined annual purchase volumes. In addition, the PSS receives fees from pharmaceutical manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of "Cost of revenues".

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

Insurance - 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.

Facility opening and closing costs - New facility opening costs, other than capital expenditures, are charged directly to expense when incurred. When the Company closes a facility, the present value of estimated unrecoverable costs, including the remaining lease obligation less estimated sublease income and the book value of abandoned property and equipment, are charged to expense. The long-term portion of the lease obligations associated with facility closings was $288 million and $327 million in 2012 and 2011, respectively.

Advertising costs - Advertising costs are expensed when the related advertising takes place. Advertising costs, net of vendor funding (included in operating expenses), were $221 million, $211 million and $234 million in 2012, 2011 and 2010, respectively.

Interest expense, net - Interest expense, net of capitalized interest, was $561 million, $588 million and $539 million, and interest income was $4 million, $4 million and $3 million in 2012, 2011 and 2010, respectively. Capitalized interest totaled $29 million, $37 million and $47 million in 2012, 2011 and 2010, respectively.

Shares held in trust - The Company maintains grantor trusts, which held approximately 1 and 2 million shares of its common stock at December 31, 2012 and 2011, respectively. These shares are designated for use under various employee compensation plans. Since the Company holds these shares, they are excluded from the computation of basic and diluted shares outstanding.

Accumulated other comprehensive loss - Accumulated other comprehensive loss consists of changes in the net actuarial gains and losses associated with pension and other postretirement benefit plans, and unrealized losses on derivatives. The amount included in accumulated other comprehensive loss related to the Company's pension and postretirement plans was $268 million pre-tax ($165 million after-tax) as of December 31, 2012 and $250 million pre-tax ($152 million after-tax) as of December 31, 2011. The net impact on cash flow hedges totaled $26 million pre-tax ($16 million after-tax) and $32 million pre-tax ($20 million after-tax) as of December 31, 2012 and 2011, 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 applicable requisite service period of the stock award (generally 3 to 5 years) using the straight-line method. Stock-based compensation is included in operating expenses.

Income taxes - The Company provides for income taxes currently payable, as well as for those deferred because of timing differences between reported income and expenses for financial statement purposes versus income tax return purposes. Income tax credits are recorded as a reduction of income taxes. Deferred income tax assets and liabilities are recognized for the future tax consequences attributable to differences between the carrying amount of assets and liabilities for financial reporting purposes and the amounts used for income tax return purposes. Deferred income tax assets and liabilities are measured using the enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recoverable or settled. The effect of a change in income tax rates is recognized as income or expense in the period of the change.

Earnings per common share - Basic earnings per common share is computed by dividing: (i) net earnings by (ii) the weighted average number of common shares outstanding during the year (the "Basic Shares").

Diluted earnings per common share is computed by dividing: (i) net earnings by (ii) Basic Shares plus the additional shares that would be issued assuming that all dilutive stock awards are exercised. Options to purchase 5.9 million, 30.5 million and 34.3 million shares of common stock were outstanding as of December 31, 2012, 2011 and 2010, respectively, but were not included in the calculation of diluted earnings per share because the options' exercise prices were greater than the average market price of the common shares and, therefore, the effect would be antidilutive.

New Accounting Pronouncements

In June 2011, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2011-05, *Presentation of Comprehensive Income* ("ASU 2011-05"). ASU 2011-05 eliminates the current option to report other comprehensive income and its components in the statement of shareholders' equity. Instead, an entity will have the option to present the total of comprehensive income, the components of net income, and the components of other comprehensive income either in a single continuous statement of comprehensive income or in two separate but consecutive statements. ASU 2011-05 also required entities to present reclassification adjustments out of accumulated other comprehensive income by component in both the statement in which net income is presented and the statement in which other comprehensive income is presented. In December 2011, the FASB issued ASU 2011-12 *Deferral of the Effective Date for Amendments to the Presentation of Reclassification of Items Out of Accumulated Other Comprehensive Income in Accounting Standards Update No. 2011-05*, which indefinitely defers the guidance related to the presentation of reclassification adjustments. ASU 2011-05 is effective for interim and annual periods beginning after December 15, 2011 and should be applied retrospectively. The Company elected to report other comprehensive income and its components in a separate statement of comprehensive income beginning in the first quarter of 2012. The adoption of ASU 2011-05 did not have a material effect on the Company's consolidated financial statements.

In September 2011, the FASB issued ASU 2011-08, *Testing Goodwill for Impairment* ("ASU 2011-08"). ASU 2011-08 allows entities to use a qualitative approach to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying value. If after performing the qualitative assessment an entity determines it is not more likely than not that the fair value of a reporting unit is less than its carrying amount, then performing the two-step goodwill impairment test is unnecessary. However, if an entity concludes otherwise, then it is required to perform the first step of the two-step goodwill impairment test. ASU 2011-08 is effective for annual and interim goodwill impairment tests performed for fiscal years beginning after December 15, 2011. The adoption of ASU 2011-08 did not have a material effect on the Company's consolidated financial statements. The Company did not elect to use the qualitative approach in its 2012 annual goodwill impairment test.

In July 2012, the FASB issued ASU 2012-02, *Testing Indefinite-Lived Intangible Assets for Impairment* ("ASU 2012-02"). ASU 2012-02 allows entities to use a qualitative approach to determine whether the existence of events and circumstances indicates that it is more likely than not that the indefinite-lived intangible asset is impaired. If, after assessing the totality of events and circumstances, an entity concludes that it is not more likely than not that the indefinite-lived intangible asset is impaired, then the entity is not required to take further action. However, if an entity concludes otherwise, then it is required to determine the fair value of the indefinite-lived intangible asset and perform the quantitative impairment test by comparing the fair value with the carrying amount and recognize an impairment loss, if any, to the extent the carrying value exceeds its fair value. ASU 2012-02 is effective for annual and interim impairment tests performed for fiscal years beginning after September 15, 2012, and early adoption is permitted. The Company did not elect to early adopt ASU 2012-02 and does not expect the adoption will have a material effect on the Company's consolidated financial statements.

2 Changes in Accounting Principle

Effective January 1, 2012, the Company changed its methods of accounting for prescription drug inventories in the Retail Pharmacy Segment. Prior to 2012, the Company valued prescription drug inventories at the lower of cost or market on a first-in, first-out ("FIFO") basis in retail pharmacies using the retail inventory method and in distribution centers using the FIFO cost method. Effective January 1, 2012, all prescription drug inventories in the Retail Pharmacy Segment have been valued at the lower of cost or market using the weighted average cost method. These changes affected approximately 51% of consolidated inventories.

These changes were made primarily to bring all of the pharmacy operations of the Company to a common inventory valuation methodology and to provide the Company with better information to manage its retail pharmacy operations. The Company believes the weighted average cost method is preferable to the retail inventory method and the FIFO cost method because it results in greater precision in the determination of cost of revenues and inventories by specific drug product and results in a consistent inventory valuation method for all of the Company's prescription drug inventories as the Pharmacy Services Segment's mail service and specialty pharmacies were already on the weighted average cost method. Most of these mail service and specialty pharmacies in the Pharmacy Services Segment were acquired in the Company's 2007 acquisition of Caremark Rx, Inc.

The Company recorded the cumulative effect of these changes in accounting principle as of January 1, 2012. The Company determined that retrospective application for periods prior to 2012 is impracticable, as the period-specific information necessary to value prescription drug inventories in the Retail Pharmacy Segment under the weighted average cost method is unavailable. The Company implemented a new pharmacy cost accounting system to value prescription drug inventory as of January 1, 2012 and calculated the cumulative impact. The effect of these changes in accounting principle as of January 1, 2012 was a decrease in inventories of $146 million, an increase in current deferred income tax assets of $57 million and a decrease in retained earnings of $89 million.

Had the Company not made these changes in accounting principle, for the year ended December 31, 2012, income from continuing operations and net income attributable to CVS Caremark would have been approximately $19 million lower. For the year ended December 31, 2012, basic and diluted earnings per common share for income from continuing operations attributable to CVS Caremark and net income attributable to CVS Caremark would have been reduced by $0.01.

3 Business Combinations

On April 29, 2011, the Company acquired the Medicare prescription drug business of Universal American Corp. (the "UAM Medicare Part D Business") for approximately $1.3 billion. The fair value of assets acquired and liabilities assumed were $2.4 billion and $1.1 billion, respectively, which included identifiable intangible assets of approximately $0.4 billion and goodwill of approximately $1.0 billion that were recorded in the PSS. The Company's results of operations and cash flows include the UAM Medicare Part D Business beginning on April 29, 2011.

In addition to the 2011 acquisition discussed above, there were two immaterial acquisitions during 2012.

4 Discontinued Operations

On November 1, 2011, the Company sold its TheraCom, L.L.C. ("TheraCom") subsidiary to AmerisourceBergen Corporation for $250 million, plus a working capital adjustment of $7 million which the Company received in March 2012. TheraCom is a provider of commercialization support services to the biotech and pharmaceutical industries. The TheraCom business had historically been part of the Company's Pharmacy Services Segment. The results of the TheraCom business are presented as discontinued operations and have been excluded from both continuing operations and segment results for all periods presented.

In connection with certain business dispositions completed between 1991 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Linens 'n Things which filed for bankruptcy in 2008. The Company's income (loss) from discontinued operations includes lease-related costs which the Company believes it will likely be required to satisfy pursuant to its Linens 'n Things lease guarantees.

Below is a summary of the results of discontinued operations:

In millions	Year Ended December 31, 2012	2011	2010
Net revenues of TheraCom	$ —	$ 650	$ 635
Income from operations of TheraCom	$ —	$ 18	$ 28
Gain on disposal of TheraCom	—	53	—
Loss on disposal of Linens 'n Things	(12)	(7)	(24)
Income tax benefit (provision)	5	(95)	(2)
Income (loss) from discontinued operations, net of tax	$ (7)	$ (31)	$ 2

5 Goodwill and Other Intangibles

Goodwill and other indefinitely-lived assets are not amortized, but are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate impairment may exist.

When evaluating goodwill for potential impairment, the Company first compares the fair value of its two reporting units, the PSS and RPS, to their respective carrying amounts. The Company estimates the fair value of its reporting units using a combination of a future discounted cash flow valuation model and a comparable market transaction model. If the estimated fair value of the reporting unit is less than its carrying amount, an impairment loss calculation is prepared. The impairment loss calculation compares the implied fair value of a reporting unit's goodwill with the carrying amount of its goodwill. If the carrying amount of the goodwill exceeds the implied fair value, an impairment loss is recognized in an amount equal to the excess. During the third quarter of 2012, the Company performed its required annual goodwill impairment tests. The Company concluded there were no goodwill impairments as of the testing date. The carrying amount of goodwill was $26.4 billion and $26.5 billion as of December 31, 2012 and 2011, respectively (see Note 14 for a breakdown of Goodwill by segment). The $63 million decrease in goodwill in 2012 was due to the finalization of the assessment of the fair value of assets acquired and liabilities assumed in the 2011 acquisition of the UAM Medicare Part D Business which decreased goodwill by $44 million, the realization of tax benefits associated with replacement stock options issued in a 2007 acquisition which decreased goodwill by $11 million, certain balance sheet adjustments to land and close store reserves related to acquisitions in previous years which decreased goodwill by $52 million, partially offset by a $44 million increase in goodwill associated with two immaterial acquisitions in 2012. These changes to goodwill affected both the PSS and RPS.

Indefinitely-lived intangible assets are tested for impairment by comparing the estimated fair value of the asset to its carrying value. The Company estimates the fair value of its indefinitely-lived trademark 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. During the third quarter of 2012, the Company performed its annual impairment test of the indefinitely-lived trademark and concluded there was no impairment as of the testing date. The carrying amount of its indefinitely-lived trademark was $6.4 billion as of December 31, 2012 and 2011.

The Company amortizes intangible assets with finite lives over the estimated useful lives of the respective assets, which have a weighted average useful life of 13.4 years. The weighted average useful lives of the Company's customer contracts and relationships and covenants not to compete are 12.9 years. The weighted average lives of the Company's favorable leases and other intangible assets are 17.3 years. Amortization expense for intangible assets totaled $486 million, $452 million and $427 million in 2012, 2011 and 2010, respectively. The anticipated annual amortization expense for these intangible assets for the next five years is $454 million in 2013, $420 million in 2014, $392 million in 2015, $364 million in 2016 and $341 million in 2017.

The following table is a summary of the Company's intangible assets as of December 31:

	2012			2011		
In millions	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount
Trademark (indefinitely-lived)	$ 6,398	$ —	$ 6,398	$ 6,398	$ —	$ 6,398
Customer contracts and relationships and covenants not to compete	5,745	(2,812)	2,933	5,427	(2,386)	3,041
Favorable leases and other	802	(380)	422	769	(339)	430
	$12,945	$(3,192)	$ 9,753	$12,594	$ (2,725)	$ 9,869

6 Share Repurchase Programs

On September 19, 2012, the Company's Board of Directors authorized a new share repurchase program for up to $6.0 billion of outstanding common stock (the "2012 Repurchase Program"). The share repurchase authorization, which was effective immediately, permits the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase transactions, and/or other derivative transactions. The 2012 Repurchase Program may be modified or terminated by the Board of Directors at any time.

On August 23, 2011, the Company's Board of Directors authorized a share repurchase program for up to $4.0 billion of outstanding common stock (the "2011 Repurchase Program"). The share repurchase authorization, which was effective immediately, permitted the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase transactions, and/or other derivative transactions.

Pursuant to the authorizations under the 2011 and 2012 Repurchase Programs, on September 19, 2012, the Company entered into a $1.2 billion fixed dollar accelerated share repurchase ("ASR") agreement with Barclays Bank PLC ("Barclays"). Upon payment of the $1.2 billion purchase price on September 20, 2012, the Company received a number of shares of its common stock equal to 50% of the $1.2 billion notional amount of the ASR agreement or approximately 12.6 million shares at a price of $47.71 per share. The Company received approximately 13.0 million shares of common stock on November 16, 2012 at an average price of $46.96 per share, representing the remaining 50% of the $1.2 billion notional amount of the ASR agreement and thereby concluding the agreement. The total of 25.6 million shares of common stock delivered to the Company by Barclays over the term of the ASR agreement were placed into treasury stock.

Pursuant to the authorization under the 2011 Repurchase Program, on August 24, 2011, the Company entered into a $1.0 billion fixed dollar ASR agreement with Barclays. The ASR agreement contained provisions that establish the minimum and maximum number of shares to be repurchased during its term. Pursuant to the ASR agreement, on August 25, 2011, the Company paid $1.0 billion to Barclays in exchange for Barclays delivering 20.3 million shares of common stock to the Company. On September 16, 2011, upon establishment of the minimum number of shares to be repurchased, Barclays delivered an additional 5.4 million shares of common stock to the Company. At the conclusion of the transaction on December 28, 2011, Barclays delivered a final installment of 1.6 million shares of common stock on December 29, 2011. The aggregate 27.3 million shares of common stock delivered to the Company by Barclays, were placed into treasury stock. This represented all the repurchases that occurred during the year ended December 31, 2011 under the 2011 Repurchase Program.

During the year ended December 31, 2012, the Company repurchased an aggregate of 95.0 million shares of common stock for approximately $4.3 billion under the 2012 and 2011 Repurchase Programs, which includes shares received from the ASR described above. As of December 31, 2012, the 2011 Repurchase Program was complete and there remained approximately $4.7 billion available for future repurchases under the 2012 Repurchase Program.

On June 14, 2010, our Board of Directors authorized a share repurchase program for up to $2.0 billion of our outstanding common stock (the "2010 Repurchase Program"). During the year ended December 31, 2011, the Company repurchased an aggregate of 56.4 million shares of common stock for approximately $2.0 billion, completing the 2010 Repurchase Program, which included shares received from the ASR described above.

On November 4, 2009, our Board of Directors authorized a share repurchase program for up to $2.0 billion of our outstanding common stock (the "2009 Repurchase Program"). During 2010, the Company repurchased 42.4 million shares of common stock for approximately $1.5 billion, completing the 2009 Repurchase Program.

7 Borrowing and Credit Agreements

The following table is a summary of the Company's borrowings as of December 31:

In millions	2012	2011
Commercial paper	$ 690	$ 750
4.875% senior notes due 2014	550	550
3.25% senior notes due 2015	550	550
6.125% senior notes due 2016	421	700
5.75% senior notes due 2017	1,310	1,750
6.6% senior notes due 2019	394	1,000
4.75% senior notes due 2020	450	450
4.125% senior notes due 2021	550	550
6.25% senior notes due 2027	1,000	1,000
Trust Preferred Securities	—	50
6.125% senior notes due 2039	1,500	1,500
5.75% senior notes due 2041	950	950
Enhanced Capital Advantage Preferred Securities due 2062[(1)]	41	42
2.75% senior notes due 2022	1,250	—
Mortgage notes payable	1	4
Capital lease obligations	171	168
	9,828	10,014
Less:		
Short-term debt (commercial paper)	(690)	(750)
Current portion of long-term debt	(5)	(56)
	$ 9,133	$ 9,208

(1) The Enhanced Capital Advantage Preferred Securities ("ECAPS") had a stated rate of interest of 6.302% through June 1, 2012, at which time the rate converted to a variable rate which was 2.59% at December 31, 2012.

The Company had $690 million of commercial paper outstanding as of December 31, 2012. In connection with its commercial paper program, the Company maintains a $1.0 billion, three-year unsecured back-up credit facility, which expires on May 27, 2013, a $1.25 billion, four-year unsecured back-up credit facility, which expires on May 12, 2015, and a $1.25 billion, five-year unsecured back-up credit facility, which expires on February 17, 2017. 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 0.05%, regardless of usage. As of December 31, 2012, there were no borrowings outstanding under the back-up credit facilities. The weighted average interest rate for short-term debt was 0.35% as of December 31, 2012 and 0.37% as of December 31, 2011.

On November 26, 2012, the Company issued $1.25 billion of 2.75% unsecured senior notes due December 1, 2022 (the "2012 Notes") for total proceeds of approximately $1.24 billion, net of discounts and underwriting fees. The 2012 Notes pay interest semi-annually and may be redeemed, in whole at any time, or in part from time to time, at the Company's option at a defined redemption price plus accrued and unpaid interest to the redemption date. The net proceeds of the 2012 Notes were used for general corporate purposes and to repay certain corporate debt.

On November 26, 2012, the Company announced tender offers for any and all of the 6.6% Senior Notes due 2019, and up to a maximum amount of the 6.125% Senior Notes due 2016 and 5.75% Senior Notes due 2017, for up to an aggregate principal amount of $1.0 billion. In December 2012, the Company increased the aggregate principal amount of the tender offers to $1.325 billion and completed the repurchase for the maximum amount. The Company paid a premium of $332 million in excess of the debt principal in connection with the tender offers, wrote off $13 million of unamortized deferred financing costs and incurred $3 million in fees, for a total loss on the early extinguishment of debt of $348 million. The loss was recorded in income from continuing operations on the consolidated statement of income.

In connection with the Company's acquisition of the UAM Medicare Part D Business in April 2011, the Company assumed $110 million of long-term debt in the form of Trust Preferred Securities that mature through 2037. During the years ended December 31, 2012 and 2011, the Company repaid $50 million and $60 million, respectively, of the Trust Preferred Securities at par.

On May 12, 2011, the Company issued $550 million of 4.125% unsecured senior notes due May 15, 2021 and issued $950 million of 5.75% unsecured senior notes due May 15, 2041 (collectively, the "2011 Notes") for total proceeds of approximately $1.5 billion, net of discounts and underwriting fees. The 2011 Notes pay interest semi-annually and may be redeemed, in whole at any time, or in part from time to time, at the Company's option at a defined redemption price plus accrued and unpaid interest to the redemption date. The net proceeds of the 2011 Notes were used to repay commercial paper borrowings and certain other corporate debt, and were used for general corporate purposes.

In December 2011 and July 2012, the Company repurchased $958 million and $1 million of the principal amount of its ECAPS at par. The fees and write-off of deferred issuance costs associated with the early extinguishment of the ECAPS were de minimis. The remaining $41 million of outstanding ECAPS at December 31, 2012 are due in 2062. The ECAPS pay interest semi-annually and may be redeemed at any time, in whole or in part at a defined redemption price plus accrued interest.

On May 13, 2010, the Company issued $550 million of 3.25% unsecured senior notes due May 18, 2015 and issued $450 million of 4.75% unsecured senior notes due May 18, 2020 (collectively, the "2010 Notes") for total proceeds of $991 million, which was net of discounts and underwriting fees. The 2010 Notes pay interest semi-annually and may be redeemed, in whole at any time, or in part from time to time, at the Company's option at a defined redemption price plus accrued and unpaid interest to the redemption date. The net proceeds of the 2010 Notes were used to repay a portion of the Company's outstanding commercial paper borrowings and certain other corporate debt, and were used for general corporate purposes.

The credit facilities, back-up credit facilities, unsecured senior notes and ECAPS contain customary restrictive financial and operating covenants. The covenants do not materially affect the Company's financial or operating flexibility.

The aggregate maturities of long-term debt for each of the five years subsequent to December 31, 2012 are $5 million in 2013, $555 million in 2014, $556 million in 2015, $427 million in 2016, and $1.3 billion in 2017.

8 Leases

The Company leases most of its retail and mail order locations, ten of its distribution centers and certain corporate offices under non-cancelable operating leases, typically with initial terms of 15 to 25 years and with options that permit renewals for additional periods. The Company also leases certain equipment and other assets under noncancelable operating leases, typically with initial terms of 3 to 10 years. Minimum rent is expensed on a straight-line basis over the term of the lease. In addition to minimum rental payments, certain leases require additional payments based on sales volume, as well as reimbursement for real estate taxes, common area maintenance and insurance, which are expensed when incurred.

The following table is a summary of the Company's net rental expense for operating leases for the respective years:

In millions	2012	2011	2010
Minimum rentals	$2,165	$2,087	$2,001
Contingent rentals	48	49	53
	2,213	2,136	2,054
Less: sublease income	(20)	(19)	(19)
	$2,193	$2,117	$2,035

The following table is a summary of the future minimum lease payments under capital and operating leases as of December 31, 2012:

In millions	Capital Leases	Operating Leases[1]
2013	$ 20	$ 2,261
2014	21	2,078
2015	21	2,019
2016	21	1,944
2017	21	1,858
Thereafter	232	17,436
Total future lease payments	336	$27,596
Less: imputed interest	(165)	
Present value of capital lease obligations	$ 171	

(1) Future operating lease payments have not been reduced by minimum sublease rentals of $263 million due in the future under noncancelable subleases.

The Company finances a portion of its store development program through sale-leaseback transactions. The properties are generally sold at net book value, which generally approximates fair value, and the resulting leases qualify and are accounted for as operating leases. The operating leases that resulted from these transactions are included in the above table. The Company does not have any retained or contingent interests in the stores and does not provide any guarantees, other than a guarantee of lease payments, in connection with the sale-leaseback transactions. Proceeds from sale-leaseback transactions totaled $529 million in 2012, $592 million in 2011 and $507 million in 2010.

9 Medicare Part D

The Company offers Medicare Part D benefits through SilverScript and Pennsylvania Life, which have contracted with CMS to be a PDP and, pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (“MMA”), must be risk-bearing entities regulated under state insurance laws or similar statutes.

SilverScript and Pennsylvania Life are licensed domestic insurance companies under the applicable laws and regulations. Pursuant to these laws and regulations, SilverScript and Pennsylvania Life must file quarterly and annual reports with the National Association of Insurance Commissioners (“NAIC”) and certain state regulators, must maintain certain minimum amounts of capital and surplus under a formula established by the NAIC and must, in certain circumstances, request and receive the approval of certain state regulators before making dividend payments or other capital distributions to the Company. The Company does not believe these limitations on dividends and distributions materially impact its financial position.

The Company has recorded estimates of various assets and liabilities arising from its participation in the Medicare Part D program based on information in its claims management and enrollment systems. Significant estimates arising from its participation in this program include: (i) estimates of low-income cost subsidy and reinsurance amounts ultimately payable to or receivable from CMS based on a detailed claims reconciliation that will occur in the following year; (ii) an estimate of amounts receivable from or payable to CMS under a risk-sharing feature of the Medicare Part D program design, referred to as the risk corridor and (iii) estimates for claims that have been reported and are in the process of being paid or contested and for our estimate of claims that have been incurred but have not yet been reported.

10 Pension Plans and Other Postretirement Benefits

Defined Contribution Plans

The Company sponsors voluntary 401(k) savings plans that cover substantially all employees who meet plan eligibility requirements. The Company makes matching contributions consistent with the provisions of the plans.

At the participant's option, account balances, including the Company's matching contribution, can be moved without restriction among various investment options, including the Company's common stock. The Company also maintains a nonqualified, unfunded Deferred Compensation Plan for certain key employees. This plan provides participants the opportunity to defer portions of their eligible compensation and receive matching contributions equivalent to what they could have received under the CVS Caremark 401(k) Plan absent certain restrictions and limitations under the Internal Revenue Code. The Company's contributions under the above defined contribution plans were $199 million, $187 million and $186 million in 2012, 2011 and 2010, respectively.

Other Postretirement Benefits

The Company provides postretirement health care and life insurance benefits to certain retirees who meet eligibility requirements. The Company's funding policy is generally to pay covered expenses as they are incurred. For retiree medical plan accounting, the Company reviews external data and its own historical trends for health care costs to determine the health care cost trend rates. As of December 31, 2012 and 2011, the Company's postretirement medical plans have an accumulated postretirement benefit obligation of $16 million and $17 million, respectively. Net periodic benefit costs related to these postretirement medical plans were approximately $1 million for 2012, 2011 and 2010.

Pursuant to various labor agreements, the Company also contributes to multiemployer health and welfare plans that cover union-represented employees. The plans provide postretirement health care and life insurance benefits to certain employees who meet eligibility requirements. Total Company contributions to multiemployer health and welfare plans were $50 million, $47 million and $46 million in 2012, 2011 and 2010, respectively.

Pension Plans

The Company sponsors nine defined benefit pension plans that cover certain full-time employees. Three of the plans are tax-qualified plans that are funded based on actuarial calculations and applicable federal laws and regulations. The other six plans are unfunded nonqualified supplemental retirement plans. All of the plans were frozen in prior periods, except two of the nonqualified plans.

As of December 31, 2012, the Company's pension plans had a projected benefit obligation of $758 million and plan assets of $527 million. As of December 31, 2011, the Company's pension plans had a projected benefit obligation of $685 million and plan assets of $463 million. Actual return on plan assets was $62 million and $37 million in 2012 and 2011, respectively. Net periodic pension costs related to these pension plans were $31 million, $49 million and $36 million in 2012, 2011 and 2010, respectively. The net periodic pension costs for 2012 include a curtailment loss of $2 million. The net periodic pension costs for 2011 and 2010 includes settlement losses of $25 million and $12 million, respectively, due to the impact of lump sum payouts.

The discount rate is determined by examining the current yields observed on the measurement date of fixed-interest, high quality investments expected to be available during the period to maturity of the related benefits on a plan by plan basis. The discount rate for the plans was 4.0% in 2012 and 4.75% in 2011. The expected long-term rate of return on plan assets is determined by using the plan's target allocation and historical returns for each asset class on a plan by plan basis. The expected long-term rate of return for all plans was 7.25% in 2012, 2011 and 2010.

Historically, the Company used an investment strategy, which emphasized equities in order to produce higher expected returns, and in the long run, lower expected expense and cash contribution requirements. The qualified pension plan asset allocation targets are 50% equity and 50% fixed income.

As of December 31, 2012, the Company's qualified defined benefit pension plan assets consisted of 50% equity, 48% fixed income, and 2% money market securities of which 84% were classified as Level 1 and 16% as Level 2 in the fair value hierarchy. The Company's qualified defined benefit pension plan assets as of December 31, 2011 consisted of 47% equity 51% fixed income, and 2% money market securities of which 82% were classified as Level 1 and 18% as Level 2 in the fair value hierarchy.

The Company contributed $36 million, $92 million and $65 million to the pension plans during 2012, 2011 and 2010, respectively. The Company plans to make approximately $33 million in contributions to the pension plans during 2013.

The Company also contributes to a number of multiemployer pension plans under the terms of collective-bargaining agreements that cover its union-represented employees. The risks of participating in these multiemployer plans are different from single-employer pension plans in the following aspects: (i) assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers, (ii) if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers, and (iii) if the Company chooses to stop participating in some of its multiemployer plans, the Company may be required to pay those plans an amount based on the underfunded status of the plan, referred to as a withdrawal liability.

None of the multiemployer pension plans the Company participates in are individually significant to the Company. Total Company contributions to multiemployer pension plans were $12 million, $11 million and $12 million in 2012, 2011 and 2010, respectively.

11 Stock Incentive Plans

Stock-based compensation expense is measured at the grant date based on the fair value of the award and is recognized as expense over the applicable requisite service period of the stock award (generally three to five years) using the straight-line method. Stock-based compensation costs are included in selling, general and administrative expenses.

Compensation expense related to stock options, which includes the 2007 Employee Stock Purchase Plan (the "2007 ESPP") totaled $102 million, $112 million and $127 million for 2012, 2011 and 2010, respectively. The recognized tax benefit was $33 million, $38 million and $42 million for 2012, 2011 and 2010, respectively. Compensation expense related to restricted stock awards totaled $30 million, $21 million and $23 million for 2012, 2011 and 2010, respectively.

The 2007 ESPP provides for the purchase of up to 15 million shares of common stock. Under the 2007 ESPP, eligible employees may purchase common stock at the end of each six month offering period at a purchase price equal to 85% of the lower of the fair market value on the first day or the last day of the offering period. During 2012, approximately 2 million shares of common stock were purchased under the provisions of the 2007 ESPP at an average price of $33.70 per share. As of December 31, 2012, approximately 3 million shares of common stock were available for issuance under the 2007 ESPP.

The fair value of stock-based compensation associated with the 2007 ESPP is estimated on the date of grant (i.e., the beginning of the offering period) using the Black-Scholes Option Pricing Model.

The following table is a summary of the assumptions used to value the ESPP awards for each of the respective periods:

	2012	2011	2010
Dividend yield[(1)]	0.73%	0.69%	0.57%
Expected volatility[(2)]	22.88%	20.42%	32.58%
Risk-free interest rate[(3)]	0.10%	0.15%	0.21%
Expected life *(in years)*[(4)]	0.5	0.5	0.5
Weighted-average grant date fair value	$ 9.22	$ 7.21	$ 7.31

(1) The dividend yield is calculated based on semi-annual dividends paid and the fair market value of the Company's stock at the grant date.

(2) The expected volatility is based on the historical volatility of the Company's daily stock market prices over the previous six month period.

(3) The risk-free interest rate is based on the Treasury constant maturity interest rate whose term is consistent with the expected term of ESPP options (i.e., 6 months).

(4) The expected life is based on the semi-annual purchase period.

In May 2010, the Company's Board of Directors adopted and the shareholders approved the 2010 Incentive Compensation Plan (the "2010 ICP"), which superseded the 1997 Incentive Compensation Plan (the "1997 ICP"). The terms of the 2010 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. 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 of the Company's Board of Directors. The 2010 ICP allows for a maximum of 74 million shares to be reserved and available for grants, plus the number of shares subject to awards under the Company's 1997 ICP which become available due to cancellation or forfeiture. Following approval and adoption of the 2010 ICP, no new grants can be made under the 1997 ICP. The 2010 ICP is the only compensation plan under which the Company grants stock options, restricted stock and other stock-based awards to its employees, with the exception of the Company's 2007 ESPP. In November 2012, the Company's Board of Director's approved an amendment to the 2010 ICP to eliminate the share recycling provision of the 2010 ICP. As of December 31, 2012, there were approximately 48 million shares available for future grants under the 2010 ICP.

The Company's restricted awards are considered non-vested share awards and require no payment from the employee. Compensation cost is recorded based on the market price on the grant date and is recognized on a straight-line basis over the requisite service period. The Company granted 1,811,000, 1,121,000 and 1,095,000 restricted stock units with a weighted average fair value of $44.80, $34.84 and $35.25 in 2012, 2011 and 2010, respectively. As of December 31, 2012, there was $67 million of total unrecognized compensation cost related to the restricted stock units that are expected to vest. These costs are expected to be recognized over a weighted-average period of 2.06 years. The total fair value of restricted shares vested during 2012, 2011 and 2010 was $81 million, $33 million and $44 million, respectively.

The following table is a summary of the restricted stock unit and restricted share award activity for the year ended December 31, 2012:

Units in thousands	Units	Weighted Average Grant Date Fair Value
Nonvested at beginning of year	2,606	$ 32.80
Granted	1,811	44.80
Vested	(1,917)	43.10
Forfeited	(150)	37.77
Nonvested at end of year	2,350	$ 33.32

All grants under the 2010 ICP are awarded at fair market value on the date of grant. The fair value of stock options is estimated using the Black-Scholes Option Pricing Model and stock-based compensation is recognized on a straight-line basis over the requisite service period. Options granted prior to 2004 generally become exercisable over a four-year period from the grant date and expire ten years after the date of grant. Options granted between 2004 and 2010 generally become exercisable over a three-year period from the grant date and expire seven years after the grant date. Beginning in 2011, options granted generally become exercisable over a four-year period from the grant date and expire seven years after the grant date.

Excess tax benefits of $28 million, $21 million and $28 million were included in financing activities in the accompanying consolidated statements of cash flow during 2012, 2011 and 2010, respectively. Cash received from stock options exercised, which includes the 2007 ESPP, totaled $836 million, $431 million and $285 million during 2012, 2011 and 2010, respectively. The total intrinsic value of options exercised was $321 million, $161 million and $118 million in 2012, 2011 and 2010, respectively. The total fair value of options vested during 2012, 2011 and 2010 was $386 million, $452 million and $445 million, respectively.

The fair value of each stock option is estimated using the Black-Scholes option pricing model based on the following assumptions at the time of grant:

	2012	2011	2010
Dividend yield[(1)]	1.44%	1.43%	1.00%
Expected volatility[(2)]	32.49%	32.62%	33.15%
Risk-free interest rate[(3)]	0.84%	1.81%	1.85%
Expected life *(in years)*[(4)]	4.7	4.7	4.3
Weighted-average grant date fair value	$ 11.12	$ 9.19	$ 9.49

(1) The dividend yield is based on annual dividends paid and the fair market value of the Company's stock at the grant date.

(2) The expected volatility is estimated using the Company's historical volatility over a period equal to the expected life of each option grant after adjustments for infrequent events such as stock splits.

(3) The risk-free interest rate is selected based on yields from U.S. Treasury zero-coupon issues with a remaining term equal to the expected term of the options being valued.

(4) The expected life represents the number of years the options are expected to be outstanding from grant date based on historical option holder exercise experience.

As of December 31, 2012, unrecognized compensation expense related to unvested options totaled $161 million, which the Company expects to be recognized over a weighted-average period of 2.18 years. After considering anticipated forfeitures, the Company expects approximately 21 million of the unvested options to vest over the requisite service period.

The following table is a summary of the Company's stock option activity for the year ended December 31, 2012:

Shares in thousands	Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term	Aggregate Intrinsic Value
Outstanding at December 31, 2011	59,107	$ 33.40	4.11	$439,671,000
Granted	8,759	$ 45.02	—	—
Exercised	(24,978)	$ 32.29	—	—
Forfeited	(1,511)	$ 35.80	—	—
Expired	(448)	$ 25.29	—	—
Outstanding at December 31, 2012	40,929	$ 36.57	4.34	$482,249,000
Exercisable at December 31, 2012	18,875	$ 34.23	2.99	$266,505,000

12 Income Taxes

The income tax provision for continuing operations consisted of the following for the respective years:

In millions	2012	2011	2010
Current:			
Federal	$2,226	$1,807	$1,884
State	410	338	344
	2,636	2,145	2,228
Deferred:			
Federal	(177)	101	(44)
State	(18)	12	(5)
	(195)	113	(49)
Total	$2,441	$2,258	$2,179

The following table is a reconciliation of the statutory income tax rate to the Company's effective income tax rate for continuing operations for the respective years:

	2012	2011	2010
Statutory income tax rate	35.0%	35.0%	35.0%
State income taxes, net of federal tax benefit	3.9	3.9	4.1
Other	(0.3)	0.4	(0.2)
Effective income tax rate	38.6%	39.3%	38.9%

The following table is a summary of the significant components of the Company's deferred tax assets and liabilities as of December 31:

In millions	2012	2011
Deferred tax assets:		
Lease and rents	$ 336	$ 325
Inventories	141	77
Employee benefits	202	253
Allowance for doubtful accounts	137	112
Retirement benefits	115	114
Net operating losses	5	6
Other	400	315
Total deferred tax assets	1,336	1,202
Deferred tax liabilities:		
Depreciation and amortization	(4,457)	(4,552)
Net deferred tax liabilities	$(3,121)	$ (3,350)

Net deferred tax assets (liabilities) are presented on the consolidated balance sheets as follows as of December 31:

In millions	2012	2011
Deferred tax assets—current	$ 663	$ 503
Deferred tax liabilities—noncurrent	(3,784)	(3,853)
Net deferred tax liabilities	$ (3,121)	$ (3,350)

The Company believes it is more likely than not the deferred tax assets will be realized during future periods.

A reconciliation of the beginning and ending amount of unrecognized tax benefits is as follows:

In millions	2012	2011	2010
Beginning balance	$ 38	$ 35	$ 61
Additions based on tax positions related to the current year	15	3	1
Additions based on tax positions related to prior years	42	13	2
Reductions for tax positions of prior years	(2)	—	(10)
Expiration of statutes of limitation	(12)	(7)	(16)
Settlements	(1)	(6)	(3)
Ending balance	$ 80	$ 38	$ 35

The Company and its subsidiaries are subject to U.S. federal income tax as well as income tax of numerous state and local jurisdictions. Substantially all material income tax matters have been concluded for fiscal years through 2007. The Company and its subsidiaries anticipate that a number of income tax examinations will conclude and statutes of limitation for open years will expire over the next twelve months, which may cause a utilization or reduction of the Company's reserve for uncertain tax positions of up to approximately $6 million.

The IRS is currently examining the Company's 2011 and 2012 consolidated U.S. income tax years pursuant to the Compliance Assurance Process ("CAP") program. The CAP program is a voluntary program under which taxpayers seek to resolve all or most issues with the IRS prior to or soon after the filing of their U.S. income tax returns, in lieu of being audited in the traditional manner. The Company and its subsidiaries are also currently under income tax examinations by a number of state and local tax authorities. As of December 31, 2012, no examination has resulted in any proposed adjustments that would result in a material change to the Company's results of operations, financial condition or liquidity.

The Company recognizes interest accrued related to unrecognized tax benefits and penalties in income tax expense. During the years ended December 31, 2012, 2011 and 2010, the Company recognized interest of approximately $4 million, $2 million and $3 million, respectively. The Company had approximately $10 million and $8 million accrued for interest and penalties as of December 31, 2012 and 2011, respectively.

There are no material reserves established at December 31, 2012 for income tax positions for which the ultimate deductibility is highly certain but for which there is uncertainty about the timing of such deductibility. If present, such items would impact deferred tax accounting, not the annual effective income tax rate, and would accelerate the payment of cash to the taxing authority to an earlier period.

The total amount of unrecognized tax benefits that, if recognized, would affect the effective income tax rate is approximately $61 million, after considering the federal benefit of state income taxes.

13 Commitments and Contingencies

Lease Guarantees

Between 1991 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores, Linens 'n Things, Marshalls, Kay-Bee Toys, Wilsons, This End Up and Footstar. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the store's lease obligations. When the subsidiaries were disposed of, the Company's guarantees remained in place, although each initial purchaser has indemnified the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries were to become insolvent and failed to make the required payments under a store lease, the Company could be required to satisfy these obligations.

As of December 31, 2012, the Company guaranteed approximately 74 such store leases (excluding the lease guarantees related to Linens 'n Things, which are discussed in Note 4), with the maximum remaining lease term extending through 2022. Management believes the ultimate disposition of any of the remaining guarantees will not have a material adverse effect on the Company's consolidated financial condition, results of operations or future cash flows.

Legal Matters

The Company is a party to legal proceedings, investigations and claims in the ordinary course of its business, including the matters described below. The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial position.

Our contingencies are subject to significant uncertainties, including, among other factors: (i) the procedural status of pending matters; (ii) whether class action status is sought and certified; (iii) whether asserted claims or allegations will survive dispositive motion practice; (iv) the extent of potential damages, fines or penalties, which are often unspecified or indeterminate; (v) the impact of discovery on the legal process; (vi) whether novel or unsettled legal theories are at issue; (vii) the settlement posture of the parties, and/or (viii) in the case of certain government agency investigations, whether a sealed *qui tam* lawsuit ("whistleblower" action) has been filed and whether the government agency makes a decision to intervene in the lawsuit following investigation.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters.

Caremark (the term "Caremark" being used herein to generally refer to any one or more pharmacy benefit management subsidiaries of the Company, as applicable) is a defendant in a *qui tam* lawsuit initially filed by a relator on behalf of various state and federal government agencies in Texas federal court in 1999. The case was unsealed in May 2005. The case seeks monetary damages and alleges that Caremark's processing of Medicaid and certain other government claims on behalf of its clients (which allegedly resulted in underpayments from our clients to the applicable government agencies) on one of Caremark's adjudication platforms violates applicable federal or state false claims acts and fraud statutes. The United States and the States of Texas, Tennessee, Florida, Arkansas, Louisiana and California intervened in the lawsuit, but Tennessee and Florida withdrew from the lawsuit in August 2006 and May 2007, respectively. Thereafter, in 2008, the Company prevailed on several motions for partial summary judgment and, following an appellate ruling from the Fifth Circuit Court of Appeals in 2011 which affirmed in part and reversed in part these prior rulings, the claims asserted in the case against Caremark have been substantially narrowed. In December 2007, the Company received a document subpoena from the Office of Inspector General ("OIG") within the U.S. Department of Health and Human Services ("HHS"), requesting information relating to the processing of Medicaid and other government agency claims on a different adjudication platform of Caremark. The Company has been providing documents and other information in response to this request for information. The Company has been conducting discussions with the United States Department of Justice ("DOJ") and the OIG regarding a possible settlement of these legal matters.

In April 2009, the State of Texas filed a purported civil enforcement action against Caremark for injunctive relief, damages and civil penalties in Travis County, Texas alleging that Caremark violated the Texas Medicaid Fraud Prevention Act and other state laws based on its processing of Texas Medicaid claims on behalf of PBM clients on one of Caremark's adjudication platforms. In September 2011, the Company prevailed on a motion for partial summary judgment against the State of Texas and narrowed the remaining claims in the lawsuit. In October 2009 and October 2010, the Company received civil investigative demands from the Office of the Attorney General of the State of Texas requesting, respectively, information produced under the OIG subpoena described above and other information related to the processing of Medicaid claims. These civil investigative demands state that the Office of the Attorney General of the State of Texas is investigating allegations currently pending under seal relating to two other adjudication platforms of Caremark. In January 2012, the parties filed joint motion with the Texas federal and state courts requesting that the lawsuits with the State of Texas be abated so that the parties can focus on completing settlement documentation relating to Caremark's processing of Texas Medicaid claims.

Caremark was named in a putative class action lawsuit filed in October 2003 in Alabama state court by John Lauriello, purportedly on behalf of participants in the 1999 settlement of various securities class action and derivative lawsuits against Caremark and others. Other defendants include insurance companies that provided coverage to Caremark with respect to the settled lawsuits. The Lauriello lawsuit seeks approximately $3.2 billion in compensatory damages plus other non-specified damages based on allegations that the amount of insurance coverage available for the settled lawsuits was misrepresented and suppressed. A similar lawsuit was filed in November 2003 by Frank McArthur, also in Alabama state court, naming as defendants Caremark, several insurance companies, attorneys and law firms involved in the 1999 settlement. This lawsuit was stayed as a later-filed class action, but McArthur was subsequently allowed to intervene in the Lauriello action. Following the close of class discovery, the trial court entered an Order on August 15, 2012 that granted the plaintiffs' motion to certify a class pursuant to Alabama Rule of civil Procedures 23(b)(3) but denied their request that the class also be certified pursuant to Rule 23(b)(1). In addition, the August 15,2012 Order appointed class representatives and class counsel. The defendants have filed a notice of appeal with the Alabama Supreme Court and the plaintiffs have filed a notice of cross-appeal. The proceedings in the trial court are stayed by statute pending a decision on the appeal and cross-appeal by the Alabama Supreme Court.

Various lawsuits have been filed alleging that Caremark has violated applicable antitrust laws in establishing and maintaining retail pharmacy networks for client health plans. In August 2003, Bellevue Drug Co., Robert Schreiber, Inc. d/b/a Burns Pharmacy and Rehn-Huerbinger Drug Co. d/b/a Parkway Drugs #4, together with Pharmacy Freedom Fund and the National Community Pharmacists Association filed a putative class action against Caremark in Pennsylvania federal court, seeking treble damages and injunctive relief. This case was initially sent to arbitration based on the contract terms between the pharmacies and Caremark. In October 2003, two independent pharmacies, North Jackson Pharmacy, Inc. and C&C, Inc. d/b/a Big C Discount Drugs, Inc., filed a putative class action complaint in Alabama federal court against Caremark and two PBM competitors, seeking treble damages and injunctive relief. The North Jackson Pharmacy case against two of the Caremark entities named as defendants was transferred to Illinois federal court, and the case against a separate Caremark entity was sent to arbitration based on contract terms between the pharmacies and Caremark. The Bellevue arbitration was then stayed by the parties pending developments in the North Jackson Pharmacy court case.

In August 2006, the Bellevue case and the North Jackson Pharmacy case were both transferred to Pennsylvania federal court by the Judicial Panel on Multidistrict Litigation for coordinated and consolidated proceedings with other cases before the panel, including cases against other PBMs. Caremark appealed the decision which vacated an order compelling arbitration and staying the proceedings in the Bellevue case and, following the appeal, the Court of Appeals reinstated the order compelling arbitration of the Bellevue case. Following remand, plaintiffs in the Bellevue case sought dismissal of their complaint to permit an immediate appeal of the reinstated order compelling arbitration and pursued an appeal to the Circuit Court of Appeals. In November 2012, the Circuit Court reversed the district court ruling and directed the parties to proceed in federal court. Motions for class certification in the coordinated cases within the multidistrict litigation, including the North Jackson Pharmacy case, remain pending. The consolidated action is now known as the In Re Pharmacy Benefit Managers Antitrust Litigation.

In November 2009, a securities class action lawsuit was filed in the United States District Court for the District of Rhode Island purportedly on behalf of purchasers of the Company's stock between May 5, 2009 and November 4, 2009. The lawsuit names the Company and certain officers as defendants and includes allegations of securities fraud relating to public disclosures made by the Company concerning the PBM business and allegations of insider trading. In addition, a shareholder derivative lawsuit was filed in December 2009 in the same court against the directors and certain officers of the Company. A derivative lawsuit is a lawsuit filed by a shareholder purporting to assert claims on behalf of a corporation against directors and officers of the corporation. This lawsuit, which was stayed pending developments in the related securities class action, includes allegations of, among other things, securities fraud, insider trading and breach of fiduciary duties and further alleges that the Company was damaged by the purchase of stock at allegedly inflated prices under its share repurchase program. In January 2011, both lawsuits were transferred to the United States District Court for the District of New Hampshire. In June 2012, the court granted the Company's motion to dismiss the securities class action. The plaintiffs subsequently filed a notice of appeal of the Court's ruling on the motion to dismiss, and the appeal is pending. The derivative lawsuit will remain stayed pending the outcome of the appeal of the securities class action.

In March 2010, the Company learned that various State Attorneys General offices and certain other government agencies were conducting a multi-state investigation of certain of the Company's business practices similar to those being investigated at that time by the U.S. Federal Trade Commission ("FTC"). Twenty-eight states, the District of Columbia and the County of Los Angeles are known to be participating in this investigation. The prior FTC investigation, which commenced in August 2009, was officially concluded in May 2012 when the consent order entered into between the FTC and the Company became final. The Company continues to cooperate in the multi-state investigation.

In March 2010, the Company received a subpoena from the OIG requesting information about programs under which the Company has offered customers remuneration conditioned upon the transfer of prescriptions for drugs or medications to our pharmacies in the form of gift cards, cash, non-prescription merchandise or discounts or coupons for non-prescription merchandise. The subpoena relates to an investigation of possible false or otherwise improper claims for payment under the Medicare and Medicaid programs. The Company has been providing documents and other information in response to this request for information.

The Company received a subpoena from the U.S. Securities and Exchange Commission ("SEC") in February 2011 and has subsequently received additional subpoenas and other requests for information. The SEC's requests relate to, among other things, public disclosures made by the Company during 2009, transactions in the Company's securities by certain officers and employees of the Company during 2009 and the purchase accounting for the Longs Drug Stores acquisition. The Company has been providing documents and other information as requested by the SEC.

In January 2012, the United States District Court for the Eastern District of Pennsylvania unsealed a first amended *qui tam* complaint filed in August 2011 by an individual relator, who is described in the complaint as having once been employed by a firm providing pharmacy prescription benefit audit and recovery services. The complaint seeks monetary damages and alleges that Caremark's processing of Medicare claims on behalf of one of its clients violated the federal false claims act. The United States, acting through the U.S. Attorney's Office in Philadelphia, Pennsylvania, declined to intervene in the lawsuit. Caremark filed a motion to dismiss the amended complaint and the DOJ filed a Statement of Interest with regard to Caremark's motion to dismiss. In December 2012, the court denied Caremark's motion to dismiss the amended complaint.

In January 2012, the Company received a subpoena from OIG requesting information about its Health Savings Pass program, a prescription drug discount program for uninsured or under insured individuals, in connection with an investigation of possible false or otherwise improper claims for payment involving HHS programs. In February 2012, the Company also received a civil investigative demand from the Office of the Attorney General of the State of Texas requesting a copy of information produced under this OIG subpoena and other information related to prescription drug claims submitted by our pharmacies to Texas Medicaid for reimbursement. The Company has been providing documents and other information in response to this request for information.

A purported shareholder derivative action was filed on behalf of nominal defendant CVS Caremark Corporation against certain of the Company's officers and members of its Board of Directors. The action was originally filed in June 2012 and, after the court granted leave to amend the original fling, an amended complaint was filed in November 2012. The amended complaint alleges a single claim for breach of fiduciary duty relating to the Company's alleged failure to properly implement internal regulatory controls to comply with the Controlled Substances Act and the Combat Methamphetamine Epidemic Act.

In November 2012, the Company received a subpoena from the OIG requesting information concerning automatic refill programs used by pharmacies to refill prescriptions for customers. The Company is cooperating and will be providing documents and other information in response to this request for information.

Effective January 15, 2013, CMS imposed intermediate sanctions on the Company's SilverScript Medicare Part D PDP, consisting of immediate suspension of further plan enrollment and marketing activities. The sanctions relate to the Company's compliance with certain Medicare Part D requirements and do not affect the enrollment status of the Company's current PDP enrollees. CMS has granted a limited waiver of these sanctions to allow the Company's PDP to continue to enroll eligible retirees of existing employer clients into its SilverScript plans and into employer group waiver plans to fulfill the Company's commitments to implement and provide employer group waiver plan services. This limited waiver currently extends through April 30, 2013, and CMS has advised the Company that it will consider further extensions of the waiver on a rolling basis. At the beginning of the 2013 Medicare Part D plan year, the Company implemented an enrollment systems conversion process and other actions to consolidate its PDP plans. These consolidation efforts have impacted the enrollment and coverage determination services the Company provides to PDP enrollees. The Company is cooperating with CMS to address the service issues resulting from the Company's plan consolidation efforts and to develop and implement a corrective action plan to resolve and remove the sanctions. The Company cannot predict how long the sanctions will remain in effect or the scope of corrective action or other remedial actions that CMS may require in order for the sanctions to be removed.

The Company is also a party to other legal proceedings and inquiries arising in the normal course of its business, none of which is expected to be material to the Company. The Company can give no assurance, however, that its business, financial condition and results of operations will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to our business, the pharmacy services, retail pharmacy or retail clinic industries or to the health care industry generally; (iii) pending or future federal or state governmental investigations of our business or the pharmacy services, retail pharmacy or retail clinic industry or of the health care industry generally; (iv) institution of government enforcement actions against us; (v) adverse developments in any pending qui tam lawsuit against us, whether sealed or unsealed, or in any future qui tam lawsuit that may be filed against us; or (vi) adverse developments in other pending or future legal proceedings against us or affecting the pharmacy services, retail pharmacy or retail clinic industry or the health care industry generally.

14 Segment Reporting

The Company currently has three reportable segments: Pharmacy Services, Retail Pharmacy and Corporate.

The Company evaluates its Pharmacy Services and Retail Pharmacy segment performance based on net revenue, gross profit and operating profit before the effect of certain intersegment activities and charges. The Company evaluates the performance of its Corporate Segment based on operating expenses before the effect of discontinued operations and certain intersegment activities and charges. See Note 1 for a description of the Pharmacy Services, Retail Pharmacy and Corporate segments and related significant accounting policies.

The following table is a reconciliation of the Company's business segments to the consolidated financial statements:

In millions	Pharmacy Services Segment[1][2]	Retail Pharmacy Segment[2]	Corporate Segment	Intersegment Eliminations[2]	Consolidated Totals
2012:					
Net revenues	$ 73,444	$ 63,654	$ —	$ (13,965)	$ 123,133
Gross profit	3,808	19,109	—	(411)	22,506
Operating profit	2,679	5,654	(694)	(411)	7,228
Depreciation and amortization	517	1,153	83	—	1,753
Total assets	36,057	29,183	1,408	(736)	65,912
Goodwill	19,646	6,749	—	—	26,395
Additions to property and equipment	422	1,555	53	—	2,030
2011:					
Net revenues	$ 58,874	$ 59,599	$ —	$ (11,373)	$ 107,100
Gross profit	3,279	17,468	—	(186)	20,561
Operating profit	2,220	4,912	(616)	(186)	6,330
Depreciation and amortization	433	1,060	75	—	1,568
Total assets	35,704	28,323	1,121	(605)	64,543
Goodwill	19,657	6,801	—	—	26,458
Additions to property and equipment	461	1,353	58	—	1,872
2010:					
Net revenues	$ 47,145	$ 57,345	$ —	$(8,712)	$ 95,778
Gross profit	3,315	17,039	—	(135)	20,219
Operating profit	2,361	4,537	(626)	(135)	6,137
Depreciation and amortization	390	1,016	63	—	1,469
Total assets	32,254	28,927	1,439	(451)	62,169
Goodwill	18,868	6,801	—	—	25,669
Additions to property and equipment	234	1,708	63	—	2,005

(1) Net revenues of the Pharmacy Services Segment include approximately $8.4 billion, $7.9 billion and $6.6 billion of Retail co-payments for the years ended December 31, 2012, 2011 and 2010, respectively.

(2) Intersegment eliminations relate to two types of transactions: (i) Intersegment revenues that occur when Pharmacy Services Segment clients use Retail Pharmacy Segment stores to purchase covered products. When this occurs, both the Pharmacy Services and Retail Pharmacy Segments record the revenue on a standalone basis and (ii) Intersegment revenues, gross profit and operating profit that occur when Pharmacy Services Segment clients, through the Company's intersegment activities (such as the Maintenance Choice program), elect to pick up their maintenance prescriptions at Retail Pharmacy Segment stores instead of receiving them through the mail. When this occurs, both the Pharmacy Services and Retail Pharmacy segments record the revenue, gross profit and operating profit on a standalone basis. Beginning in the fourth quarter of 2011, the Maintenance Choice eliminations reflect all discounts available for the purchase of mail order prescription drugs. The following amounts are eliminated in consolidation in connection with the item (ii) intersegment activity: net revenues of $3.4 billion, $2.6 billion and $1.8 billion for the years ended December 31, 2012, 2011 and 2010, respectively; gross profit and operating profit of $411 million, $186 million and $135 million for the years ended December 31, 2012, 2011 and 2010, respectively.

15 Earnings Per Common Share

The following is a reconciliation of basic and diluted earnings per common share for the respective years:

In millions, except per share amounts	2012	2011	2010
Numerator for earnings per common share calculation:			
Income from continuing operations	$ 3,882	$ 3,488	$ 3,422
Net loss attributable to noncontrolling interest	2	4	3
Income from continuing operations attributable to CVS Caremark, basic	3,884	3,492	3,425
Income (loss) from discontinued operations, net of tax	(7)	(31)	2
Net income attributable to CVS Caremark, basic and diluted	$ 3,877	$ 3,461	$ 3,427
Denominator for earnings per common share calculation:			
Weighted average common shares, basic	1,271	1,338	1,367
Stock options	8	8	8
Restricted stock units	1	1	2
Weighted average common shares, diluted	1,280	1,347	1,377
Basic earnings per common share:			
Income from continuing operations attributable to CVS Caremark	$ 3.06	$ 2.61	$ 2.51
Loss from discontinued operations attributable to CVS Caremark	(0.01)	(0.02)	—
Net income attributable to CVS Caremark	$ 3.05	$ 2.59	$ 2.51
Diluted earnings per common share:			
Income from continuing operations attributable to CVS Caremark	$ 3.03	$ 2.59	$ 2.49
Loss from discontinued operations attributable to CVS Caremark	(0.01)	(0.02)	—
Net income attributable to CVS Caremark	$ 3.03	$ 2.57	$ 2.49

16 Quarterly Financial Information (Unaudited)

In millions, except per share amounts	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Year
2012:					
Net revenues	$ 30,798	$ 30,714	$ 30,227	$ 31,394	$123,133
Gross profit	5,113	5,449	5,647	6,297	22,506
Operating profit	1,404	1,708	1,814	2,302	7,228
Income from continuing operations	776	966	1,011	1,129	3,882
Loss from discontinued operations, net of tax	(1)	(1)	(5)	—	(7)
Net income	775	965	1,006	1,129	3,875
Net loss attributable to noncontrolling interest	1	1	—	—	2
Net income attributable to CVS Caremark	$ 776	$ 966	$ 1,006	$ 1,129	$ 3,877
Basic earnings per common share:					
Income from continuing operations attributable to CVS Caremark	$ 0.60	$ 0.76	$ 0.80	$ 0.91	$ 3.06
Loss from discontinued operations attributable to CVS Caremark	$ —	$ —	$ —	$ —	$ (0.01)
Net income attributable to CVS Caremark	$ 0.60	$ 0.76	$ 0.80	$ 0.91	$ 3.05
Diluted Earnings per common share:					
Income from continuing operations attributable to CVS Caremark	$ 0.59	$ 0.75	$ 0.79	$ 0.90	$ 3.03
Loss from discontinued operations attributable to CVS Caremark	$ —	$ —	$ —	$ —	$ (0.01)
Net income attributable to CVS Caremark	$ 0.59	$ 0.75	$ 0.79	$ 0.90	$ 3.03
Dividends per common share	$ 0.1625	$ 0.1625	$ 0.1625	$ 0.1625	$ 0.6500
Stock price: (New York Stock Exchange)					
High	$ 45.88	$ 46.93	$ 48.69	$ 49.80	$ 49.80
Low	$ 41.01	$ 43.08	$ 43.65	$ 44.33	$ 41.01

In millions, except per share amounts	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Year
2011:					
Net revenues	$ 25,695	$ 26,414	$ 26,674	$ 28,317	$107,100
Gross profit	4,742	5,086	5,178	5,555	20,561
Operating profit	1,305	1,484	1,584	1,957	6,330
Income from continuing operations	709	813	867	1,099	3,488
Income (loss) from discontinued operations, net of tax	3	2	—	(36)	(31)
Net income	712	815	867	1,063	3,457
Net loss attributable to noncontrolling interest	1	1	1	1	4
Net income attributable to CVS Caremark	$ 713	$ 816	$ 868	$ 1,064	$ 3,461
Basic earnings per common share:					
Income from continuing operations attributable to CVS Caremark	$ 0.52	$ 0.60	$ 0.65	$ 0.84	$ 2.61
Income (loss) from discontinued operations attributable to CVS Caremark	$ —	$ —	$ —	$ (0.03)	$ (0.02)
Net income attributable to CVS Caremark	$ 0.52	$ 0.60	$ 0.65	$ 0.82	$ 2.59
Diluted Earnings per common share:					
Income from continuing operations attributable to CVS Caremark	$ 0.52	$ 0.60	$ 0.65	$ 0.84	$ 2.59
Income (loss) from discontinued operations attributable to CVS Caremark	$ —	$ —	$ —	$ (0.03)	$ (0.02)
Net income attributable to CVS Caremark	$ 0.52	$ 0.60	$ 0.65	$ 0.81	$ 2.57
Dividends per common share	$ 0.125	$ 0.125	$ 0.125	$ 0.125	$ 0.500
Stock price: (New York Stock Exchange)					
High	$ 35.95	$ 39.50	$ 38.82	$ 41.35	$ 41.35
Low	$ 32.08	$ 34.21	$ 31.30	$ 32.28	$ 31.30

Five-Year Financial Summary

In millions, except per share amounts	2012[1][5]	2011[1]	2010[1]	2009[1]	2008[1]
Statement of operations data:					
Net revenues	$123,133	$107,100	$ 95,778	$ 98,215	$ 87,005
Gross profit	22,506	20,561	20,219	20,358	18,272
Operating expenses	15,278	14,231	14,082	13,933	12,237
Operating profit	7,228	6,330	6,137	6,425	6,035
Interest expense, net	557	584	536	525	509
Loss on early extinguishment of debt	348	—	—	—	—
Income tax provision[2]	2,441	2,258	2,179	2,200	2,189
Income from continuing operations	3,882	3,488	3,422	3,700	3,337
Income (loss) from discontinued operations, net of tax benefit[3]	(7)	(31)	2	(4)	(125)
Net income	3,875	3,457	3,424	3,696	3,212
Net loss attributable to noncontrolling interest[4]	2	4	3	—	—
Preference dividends, net of income tax benefit	—	—	—	—	(14)
Net income attributable to CVS Caremark	$ 3,877	$ 3,461	$ 3,427	$ 3,696	$ 3,198
Per common share data:					
Basic earnings per common share:					
Income from continuing operations attributable to CVS Caremark	$ 3.06	$ 2.61	$ 2.51	$ 2.58	$ 2.32
Loss from discontinued operations attributable to CVS Caremark	(0.01)	(0.02)	—	—	(0.09)
Net income attributable to CVS Caremark	$ 3.05	$ 2.59	$ 2.51	$ 2.58	$ 2.23
Diluted earnings per common share:					
Income from continuing operations attributable to CVS Caremark	$ 3.03	$ 2.59	$ 2.49	$ 2.55	$ 2.27
Loss from discontinued operations attributable to CVS Caremark	(0.01)	(0.02)	—	—	(0.09)
Net income attributable to CVS Caremark	$ 3.03	$ 2.57	$ 2.49	$ 2.55	$ 2.18
Cash dividends per common share	$0.65000	$0.50000	$0.35000	$0.30500	$0.25800
Balance sheet and other data:					
Total assets	$ 65,912	$ 64,543	$ 62,169	$ 61,641	$ 60,960
Long-term debt	$ 9,133	$ 9,208	$ 8,652	$ 8,756	$ 8,057
Total shareholders' equity	$ 37,704	$ 38,051	$ 37,700	$ 35,768	$ 34,574
Number of stores (at end of year)	7,508	7,388	7,248	7,095	6,997

(1) On December 23, 2008, our Board of Directors approved a change in our fiscal year-end from the Saturday nearest December 31 of each year to December 31 of each year to better reflect our position in the health care, rather than the retail, industry. The fiscal year change was effective beginning with the fourth quarter of fiscal 2008. As you review our operating performance, please consider that 2012 includes 366 days, 2011, 2010 and 2009 include 365 days, and fiscal 2008 includes 368 days.

(2) Income tax provision includes the effect of the following: (i) in 2010, the recognition of $47 million of previously unrecognized tax benefits, including interest, relating to the expiration of various statutes of limitation and settlements with tax authorities and (ii) in 2009, the recognition of $167 million of previously unrecognized tax benefits, including interest, relating to the expiration of various statutes of limitation and settlements with tax authorities.

(3) As discussed in Note 4 to the consolidated financial statements, the results of the TheraCom business are presented as discontinued operations and have been excluded from continuing operations for all periods presented.

In connection with certain business dispositions completed between 1991 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Linens 'n Things which filed for bankruptcy in 2008. The Company's income (loss) from discontinued operations includes lease-related costs which the Company believes it will likely be required to satisfy pursuant to its Linens 'n Things lease guarantees.

Below is a summary of the results of discontinued operations:

	Fiscal Year				
In millions	2012	2011	2010	2009	2008
Income from operations of TheraCom	$ —	$ 18	$ 28	$ 13	$ 11
Gain on disposal of TheraCom	—	53	—	—	—
Loss on disposal of Linens 'n Things	(12)	(7)	(24)	(19)	(214)
Income tax benefit (provision)	5	(95)	(2)	2	78
Income (loss) from discontinued operations, net of tax	$ (7)	$ (31)	$ 2	$ (4)	$ (125)

(4) Represents the minority shareholders' portion of the net loss from our majority owned subsidiary, Generation Health, Inc., acquired in the fourth quarter of 2009. In June 2012, the Company acquired the remaining 40% interest in Generation Health, Inc. from minority shareholders and employee option holders for $26 million and $5 million, respectively, for a total of $31 million.

(5) Effective January 1, 2012, the Company changed its methods of accounting for prescription drug inventories in the Retail Pharmacy Segment. Additional details of the accounting change are discussed in Note 2 to the consolidated financial statements.

Report of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders of CVS Caremark Corporation

We have audited the accompanying consolidated balance sheets of CVS Caremark Corporation as of December 31, 2012 and 2011, and the related consolidated statements of income, comprehensive income, shareholders' equity, and cash flows for each of the three years in the period ended December 31, 2012. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of CVS Caremark Corporation at December 31, 2012 and 2011, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2012, in conformity with U.S. generally accepted accounting principles.

As discussed in Note 2 to the consolidated financial statements, the Company has elected changes in its methods of accounting for prescription drug inventories in the Retail Pharmacy Segment effective January 1, 2012.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), CVS Caremark Corporation's internal control over financial reporting as of December 31, 2012, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 15, 2013 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Boston, Massachusetts
February 15, 2013

Exhibit 21

SUBSIDIARIES OF THE REGISTRANT

As of December 31, 2012, CVS Caremark Corporation had the following significant subsidiaries:

Caremark, L.L.C. (a California limited liability company)
CaremarkPCS Health, L.L.C. (a Delaware limited liability company)
Caremark PhC, L.L.C. (a Delaware limited liability company)
Caremark Rx, L.L.C. (a Delaware limited liability company)[2]
CVS Albany, L.L.C. (a New York limited liability company)
CVS Caremark Part D Services, L.L.C. (a Delaware limited liability company)
CVS Pharmacy, Inc. (a Rhode Island corporation)[1]
Garfield Beach CVS, L.L.C. (a California limited liability company)
Holiday CVS, L.L.C. (a Florida limited liability company)
Longs Drug Stores California, L.L.C. (a California limited liability company)
MemberHealth LLC (a Delaware limited liability company)
Pennsylvania CVS Pharmacy, L.L.C. (a Pennsylvania limited liability company)
RxAmerica, LLC (a Delaware limited liability company)
SilverScript Insurance Company (a Tennessee corporation)

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(1) CVS Pharmacy, Inc. is the immediate or indirect parent of approximately 45 entities that operate drugstores, all of which drugstores are in the United States and its territories.

(2) Caremark Rx, L.L.C., the parent of the Registrant's pharmacy services subsidiaries, is the immediate or indirect parent of several mail order, specialty mail and retail specialty pharmacy subsidiaries, all of which operate in the United States and its territories.

Exhibit 23

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the following Registration Statements:

(1) Registration Statement (Form S-3 No. 333-165672) of CVS Caremark Corporation, and
(2) Registration Statements (Form S-8 Nos. 333-49407, 333-34927, 333-28043, 333-91253, 333-63664, 333-139470, 333-141481 and 333-167746) of CVS Caremark Corporation;

of our reports dated February 15, 2013, with respect to the consolidated financial statements of CVS Caremark Corporation and the effectiveness of internal control over financial reporting of CVS Caremark Corporation, incorporated by reference in this Annual Report (Form 10-K) for the year ended December 31, 2012, and to the reference to our firm under the heading "Selected Financial Data", included therein.

/s/ Ernst & Young LLP

Boston, Massachusetts
February 15, 2013

Exhibit 31.1

Certification Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

I, Larry J. Merlo, President and Chief Executive Officer of CVS Caremark Corporation, certify that:

1. I have reviewed this annual report on Form 10-K of CVS Caremark Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, 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;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors:

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 15, 2013

By: /s/ LARRY J. MERLO

Larry J. Merlo
President and
Chief Executive Officer

Exhibit 31.2

Certification Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

I, David M. Denton, Executive Vice President and Chief Financial Officer of CVS Caremark Corporation, certify that:

1. I have reviewed this annual report on Form 10-K of CVS Caremark Corporation;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
   (a) Designed such disclosure controls and procedures or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, 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;
   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors:
   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 15, 2013

By: /s/ DAVID M. DENTON

David M. Denton
Executive Vice President and Chief Financial Officer

Exhibit 32.1

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

The certification set forth below is being submitted in connection with the Annual Report of CVS Caremark Corporation (the "Company") on Form 10-K for the period ended December 31, 2012 (the "Report"), for the purpose of complying with Rule 13(a)-14(b) or Rule 15d-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

I, Larry J. Merlo, President and Chief Executive Officer of the Company, certify that, to the best of my knowledge:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Exchange Act; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and result of operations of the Company.

February 15, 2013

/S/ LARRY J. MERLO

Larry J. Merlo
President and
Chief Executive Officer

Exhibit 32.2

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

The certification set forth below is being submitted in connection with the Annual Report of CVS Caremark Corporation (the "Company") on Form 10-K for the period ended December 31, 2012 (the "Report"), for the purpose of complying with Rule 13(a)-14(b) or Rule 15d-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

I, David M. Denton, Executive Vice President and Chief Financial Officer of the Company, certify that, to the best of my knowledge:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Exchange Act; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and result of operations of the Company.

February 15, 2013

/S/ DAVID M. DENTON

David M. Denton
Executive Vice President and Chief Financial Officer