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, 2010

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 $39,599,675,690 as of June 30, 2010, 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 11, 2011, the registrant had 1,368,174,000 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:

- Information contained on pages 20 through 80 and page 83 of our Annual Report to Stockholders for the fiscal year ended December 31, 2010 is incorporated by reference in our response to Items 7, 8 and 9 of Part II.
- Information contained in our Proxy Statement for the 2011 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 pharmacy health care provider in the United States. As a fully integrated pharmacy services company, we deliver value for our customers by effectively managing pharmaceutical costs and improving health care outcomes through our pharmacy benefit management, mail order and specialty pharmacy division, CVS Caremark Pharmacy Services® ("Caremark"); our approximately 7,200 CVS/pharmacy® retail stores; our retail-based health clinic subsidiary, MinuteClinic®; and our online pharmacy, CVS.com®.

CVS Caremark is 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.

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

Pharmacy Services Segment

The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") services including mail order pharmacy services, specialty pharmacy services, plan design and administration, formulary management and claims processing. 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. In addition, through our SilverScript Insurance Company ("SilverScript") and Accendo Insurance Company ("Accendo") subsidiaries, we are a national provider of drug benefits to eligible beneficiaries under the Federal Government's Medicare Part D program. Currently, the pharmacy services business operates under the CVS Caremark Pharmacy Services®, Caremark®, CVS Caremark™, CarePlus CVS/pharmacy™, CarePlus™, RxAmerica®, Accordant® and TheraCom® names. As of December 31, 2010, the Pharmacy Services segment operated 44 retail specialty pharmacy stores, 18 specialty mail order pharmacies and four mail service pharmacies located in 25 states, the District of Columbia and Puerto Rico.

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 healthcare costs. We produce superior results for our clients and their plan members by leveraging our expertise in core PBM services, including (as described more fully below): plan design and administration, formulary management, drug purchasing arrangements, mail order services, specialty pharmacy services, retail pharmacy network management services, Medicare Part D services and a broad array of clinical services.

In addition, as a fully integrated pharmacy services company, we are able to offer our clients and their plan members a variety of new programs and plan designs that benefit from our integrated information systems and the ability of our more than 25,000 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 healthcare outcomes. Examples of these programs and services include Maintenance Choice®, a program where eligible members in plans sponsored by Pharmacy Services clients can elect to fill their maintenance prescriptions at our retail pharmacy stores instead of receiving them through the mail; Pharmacy Advisor™, a new program that uses our Consumer Engagement Engine™ technology to facilitate face-to-face counseling by our pharmacists to plan members of participating

PBM clients concerning health and safety matters, including adherence issues, gaps in care and management of certain chronic health conditions; new 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 healthcare 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 unique services available at MinuteClinic such as injection training for specialty pharmacy services.

While certain of these programs and services have already been adopted by many of our clients, others are in the formative stage and require additional information system enhancements and/or changes in work processes. Accordingly, there can be no assurance as to timing or benefits associated with certain of these programs.

PBM Services - The PBM services we provide for our clients involve the design and administration of programs aimed at reducing the cost and improving the safety, effectiveness and convenience of prescription drug use. These 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 medications prescribed by their physicians. 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 plans 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 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.

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.

Mail Pharmacy Program - As of December 31, 2010, we operated four large, automated mail service pharmacies in the continental 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, 2010, our specialty pharmacies were comprised of 18 specialty mail order pharmacies located throughout the United States and 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 18,000 health care organizations and programs in the United States. As of December 31, 2010, the Company operated a network of 44 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. Through our TheraCom subsidiary, we provide new product launch and other services for manufacturers of specialty drugs.

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 members with a convenient alternative for filling their prescriptions.

Retail Pharmacy Network - We maintain a national network of approximately 65,000 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.

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 Accendo, which have been approved by the Centers for Medicare and Medicaid Services ("CMS"), as PDPs, 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. In December 2010, the Company announced it had entered into an agreement to acquire the Medicare Part D business of Universal American Corp. ("UAC") for approximately $1.25 billion. The transaction is subject to customary closing conditions, including necessary regulatory approvals, as well as approval by UAC shareholders. The Company currently expects that the transaction will close by the end of the second quarter of 2011.

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, 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 AccordantCare 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 ("NCQA"), a private, not-for-profit organization that evaluates, accredits and certifies a wide range of health care organizations. In addition, we have entered into a strategic alliance with Alere, L.L.C. for the management of our common disease management program offerings, which cover such chronic diseases as asthma, diabetes, congestive heart failure and coronary artery disease.

Quality Assurance - We have adopted and implemented clinical quality assurance procedures as well as policies and procedures to help ensure regulatory compliance under our quality assurance programs. Each new mail service prescription undergoes a sequence of safety and accuracy checks and is reviewed and verified by a registered pharmacist before shipment. We also analyze drug-related outcomes to identify opportunities to improve the quality of care.

Pharmacogenomic Services - In the fourth quarter of 2009, we acquired a majority interest in Generation Health, Inc., a genetic benefit management company, that will allow us to expand our offering of pharmacogenomic clinical and testing services to our PBM clients. Pharmacogenomics is the study of how genetic makeup affects an individual's response to drug therapies. Through genetic testing, doctors are able to evaluate a patient's genetic makeup to determine the effectiveness of specific drugs, drug dosages and drug combinations. Through this relationship, we expect to use genetic testing to apply greater precision to client prescription management, with the goal of improving individual health outcomes and reducing overall medical costs. We began to offer these services on a limited pilot basis to clients during 2010 and plan to roll out these services to clients on a broader basis during 2011.

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 PBM clients' service contracts.

Pharmacy Services Clients - Our clients are primarily sponsors of health benefit plans (employers, unions, government employee groups, insurance companies and managed care organizations) 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 consolidated revenues in 2010. Our client agreements are subject to renegotiation of terms. See "Risk Factors – Efforts to reduce reimbursement levels and alter health care financing practices could adversely affect our business" and "- Risks of declining gross margins in the PBM industry." During the year ended December 31, 2010, our PBM filled or managed approximately 585 million prescriptions.

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 competes with a number of large, national PBM companies, including Medco Health Solutions, Inc. and Express Scripts, Inc., as well as many smaller local or regional PBMs. We also compete with several large health insurers/managed care plans (e.g., United Healthcare and CIGNA) and retail pharmacies, which have their own PBM capabilities, as well as with several other national and regional companies which provide services similar to ours.

Retail Pharmacy Segment

As of December 31, 2010, the Retail Pharmacy segment included 7,182 retail drugstores, of which 7,123 operated a pharmacy, our online retail website, CVS.com, and our retail health care clinics. The retail drugstores are located in 41 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 72 of these markets. CVS/pharmacy stores sell prescription drugs and a wide assortment of general merchandise, which we refer to as "front store" products. Existing retail stores range in size from approximately 8,000 to 25,000 square feet, although most new stores range in size from approximately 10,000 to 13,000 square feet and typically include a drive-thru pharmacy. During 2010, we filled approximately 636 million retail prescriptions, or approximately 18% of the U.S. retail pharmacy market.

As of December 31, 2010, we operated 560 retail health care clinics in 26 states and the District of Columbia under the MinuteClinic name, of which 550 were located within CVS/pharmacy stores. The clinics utilize nationally recognized medical protocols to diagnose and treat minor health conditions, perform health screenings, monitor chronic conditions and deliver vaccinations. The clinics are staffed by board-certified nurse practitioners and physician assistants who provide access to affordable care without appointment.

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 operating strategy is to 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, film and 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]		
	2010	2009	2008
Prescription drugs	68%	68%	68%
Over-the-counter and personal care	11	11	13
Beauty/cosmetics	5	5	4
General merchandise and other	16	16	15
	100%	100%	100%

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

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 brand and proprietary brand products that are only available through CVS. We currently carry over 4,400 CVS brand and proprietary brand products, which accounted for approximately 17% of our front store revenues during 2010.

Pharmacy - Pharmacy revenues represented more than two-thirds of Retail Pharmacy revenues in each of 2010, 2009 and 2008. 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, 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 (a flexible fulfillment option that affords eligible PBM plan members the convenient choice of filling their 90-day supply of maintenance medications at any CVS/pharmacy store or obtaining them through mail order, in either case at the cost of mail, which is typically lower for both the plan member and payor); Pharmacy Advisor, our new program that uses our Consumer Engagement Engine technology to facilitate face-to-face pharmacist counseling to plan members of participating PBM clients concerning health and safety matters, including adherence issues, gaps in care and management of certain chronic 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 new pharmacy fulfillment system, Rx Connect™; our touch-tone telephone reorder system, Rapid Refill™; and our online business, CVS.com.

MinuteClinic - As of December 31, 2010, we operated 560 MinuteClinics in 26 states and the District of Columbia; 550 of which 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 an excellent quality of care at an affordable price, 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 more than 80% of MinuteClinics' total revenues in 2010. We anticipate opening up 100 new clinics in CVS/pharmacy stores during 2011.

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 2010, we opened 179 new retail pharmacy stores, relocated 106 stores and closed 22 stores. During the last five years, we opened more than 1,400 new and relocated stores, and acquired approximately 1,200 stores. During 2011, we expect to open between 225 and 250 new or relocated stores, and close approximately 15 stores. 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 a high level of customer service while lowering costs and increasing operating efficiency. In 2009, we began the rollout of Rx Connect, which reengineered the way our pharmacists communicate and fill prescriptions. The rollout of Rx Connect was completed in September 2010. Our new Consumer Engagement Engine technology enables us to message pharmacists at the point of care which facilitates face-to-face counseling by our pharmacies regarding patient health and safety matters, including adherence issues, gaps in care and management of certain chronic health conditions. We were one of the first in the industry to introduce Drug Utilization Review technology that checks for harmful interactions between prescription drugs, over-the-counter products, vitamins and herbal remedies. We were also one of the first in the industry to install a chain wide automatic prescription refill system, CVS Rapid Refill, which enables customers to order prescription refills 24 hours a day using a touch-tone telephone. We continue to enhance our Visible Improvement in Profits, Execution and Results ("VIPER") system, a transaction-monitoring application designed to mitigate inventory losses attributable to process deficiencies or fraudulent behavior by providing visibility to transactions processed through our point-of-sale systems. In addition, we operate distribution centers with fully integrated technology solutions for storage, product retrieval and order picking.

Retail Pharmacy Customers - Managed care and other third party plans accounted for 97.4% of our 2010 pharmacy revenues. Since our revenues relate to numerous payors, including employers and managed care organizations, the loss of any one payor should not have a material effect on our business. No single commercial retail payor accounts for 10% or more of our total consolidated revenues. We also fill prescriptions for many government funded programs, including State Medicaid plans and Federal Medicare Part D drug plans. 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 could adversely affect our businesses*."

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" on page 80 in our Annual Report to Stockholders for the fiscal year ended December 31, 2010, 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 each of the markets we serve, we compete with independent

and other retail drugstore chains, supermarkets, convenience stores, pharmacy benefit managers and other mail order prescription providers, discount merchandisers, membership clubs, health clinics and Internet pharmacies.

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" on page 33 in our Annual Report to Stockholders for the year ended December 31, 2010, which section is incorporated by reference herein. The majority of our non-pharmacy revenues are paid in cash, or by debit and by credit cards, while managed care and other third party insurance programs, which typically settle in less than 30 days, represented approximately 98.8% of our consolidated pharmacy revenues, including both Retail Pharmacy and Pharmacy Services combined, in 2010. Our customer returns are not significant.

Associate Development

As of December 31, 2010, we employed approximately 201,000 associates, which included more than 25,000 pharmacists, nurse practitioners and physician assistants. In addition, approximately 79,000 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 or applied to register a variety of trademarks, service marks and trade names used in our business. 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 - As a participant in the health care industry, our retail and pharmacy services businesses are 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 managed care organizations ("MCOs"), 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 financial condition.

PPACA - Congress passed major health reform legislation in 2010, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, "PPACA"), which were signed into law by the President on March 23, 2010 and March 30, 2010, respectively. This legislation affects the entire health insurance system and virtually every aspect of health care in the country, although many provisions of the PPACA are not effective immediately. Given that many of the regulations implementing PPACA have not yet been issued or finalized and there is ongoing sub-regulatory guidance being issued, there is still considerable uncertainty as to its full impact. Further, aspects of the legislation are being challenged in lawsuits across the country, and some in Congress are seeking to repeal the law or portions of it. There have already been a number of conflicting court rulings calling into question the constitutionality of all or certain portions of PPACA. In addition to establishing the framework for every individual to have health coverage beginning in 2014, PPACA 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.

Among the more significant PPACA 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. The United States Department of Health and Human Services ("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. Depending on if and how this example is clarified in final regulations, health plan clients that are subject to the MLR requirements may request pricing modifications, include requests to contract using pass-through retail network pricing.

Another PPACA 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 rates 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. It is anticipated that this reporting will be required for Medicare Part D in 2012 and for qualified health plans in 2014 upon the implementation of the health insurance exchanges to be established under PPACA. PPACA also made significant changes to the Medicare and Medicaid programs, fraud and abuse laws and tax provisions. Some of the relevant changes are discussed in other sections below.

In addition to PPACA, among the existing federal and state laws and regulations that affect aspects of our business are the following:

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 HHS and administrative bodies. A broad interpretation of the federal anti-remuneration law is supported by PPACA, 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. 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 PPACA, additional statutory exceptions have been created to permit the provision of certain incentives to federal healthcare program beneficiaries, including retailer coupons, rebates or other rewards and incentives offered to promote access to care.

In April 2003, the OIG issued Compliance Program Guidance for Pharmaceutical Manufacturers (the "OIG Guidance"). In the OIG Guidance, the OIG identifies potential risk areas for pharmaceutical manufacturers and also discusses a number of traditional relationships between pharmaceutical manufacturers and PBMs, such as discount payments, service offerings and data sales, and recommends that such relationships be structured wherever possible to fit within an applicable safe harbor.

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 manufactures 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. 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 - PPACA requires that 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" 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, which applies to plans or programs to induce the purchase of goods or services by consumers. (See the Telemarketing and Other Outbound Calls 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 contracts that grant audit rights and set forth applicable audit procedures. Because some of our contracts are with state or federal governments, 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 PDPs or Medicare Advantage organizations under the MMA. 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 or arrange for PBM plan members to receive clinical services in the form of disease management programs for common and rare 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 American Recovery and Reinvestment Act of 2009 ("ARRA"), which was signed into law in February 2009, amended the Social Security Act to establish incentive payments to 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 providers in the Medicare program that fail to adopt and meaningfully use certified EHR technology. Among the measures of meaningful use is the use of electronic prescribing. A final rule implementing the EHR incentive program was issued in July 2010 which requires that at least 40% of permissible prescriptions be sent electronically in order to qualify for the incentive payments. 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. We periodically receive information requests and notices of potential noncompliance with environmental laws and regulations from governmental agencies, which are addressed on a case-by-case basis with the relevant agency.

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 November 2007, the DOL announced final revisions to Form 5500 and its related schedules effective for plan years beginning on or after January 1, 2009. The revised Form 5500, which most pension and welfare plans subject to ERISA are required to file, includes modifications to Schedule C on which plans are required to report compensation paid to service providers.

In December 2009, the DOL also announced a new project to promulgate regulations under Section 408(b)(2) of ERISA. The regulations, which were previously issued in proposed form, could require service providers, including PBMs, to provide detailed disclosure regarding all direct and indirect compensation to be received in connection with the services to be provided, as well as potential conflicts of interest.

We cannot be certain the extent to which newly issued disclosure regulations may apply to our business as the DOL has provided very little final guidance regarding what constitutes reportable compensation under a PBM agreement.

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 Federal False Claims Act ("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. PPACA 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 PPACA clarified that the retention of overpayments beyond the repayment deadline is a violation of the FCA. In addition, PPACA 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 PPACA. PPACA 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 addition, federal and state governments have commenced numerous investigations of various pharmaceutical manufacturers, PBMs, pharmacies and health care providers in recent years with respect to false claims, fraudulent billing and related matters. The federal government has entered into settlement agreements with several companies in the pharmaceutical services industry following claims by the federal government that such parties violated the FCA by: (i) improperly marketing and pricing drugs; (ii) overstating the average wholesale prices of products; (iii) paying illegal remuneration to induce the purchase of drugs; and/or (iv) failing to accurately report "best price" under the Medicaid program.

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. 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. 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.

Formulary Regulation - A number of states have begun to 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 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. 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 - In September 2005, Caremark's subsidiary, AdvancePCS (now known as CaremarkPCS, L.L.C.), entered into a settlement agreement with the federal government relating to certain alleged PBM business practices, pursuant to which AdvancePCS agreed, among other things, to adhere to certain business practices pursuant to a consent order and to maintain a compliance program in accordance with a corporate integrity agreement entered into with the OIG for a period of five years. This corporate integrity agreement expired by its terms in September 2010. However, our PBM business remains subject to the terms of a consent order entered into with a number of states in the first quarter of 2008 relating to certain of our PBM business practices.

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. Failure to meet our obligations under this corporate integrity agreement 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 has a three year term and 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 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 repotting, 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.

Managed Care Reform - In addition to health reforms enacted by PPACA, 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 PPACA. 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". This regulatory change has reduced the profitability of our Medicare Part D business. Other regulatory changes effective for the 2010 plan year include: requiring that any rebates retained by the PBM reduce the Medicare Part D sponsor's drug costs reported to the government, regardless of the terms of the contract between the PBM and Medicare Part D sponsor; requiring that clean claims from pharmacies be paid within 14 days (for electronic claims) or 30 days (for non-electronic claims); and that substantially all drugs in certain clinical classes be included on formularies.

Regulatory changes effective for the 2011 plan year include giving CMS greater latitude to limit the number of Medicare Part D plans available by allowing it to eliminate plans with persistently low enrollment and plans that it views as poor performers based on certain CMS performance criteria, shortening the period for Medicare Part D sponsors that acquire other Medicare Part D plans to merge the plans or otherwise change them so that their plan offerings remain substantially different, and limiting the period for coordination of benefits to three years for all payers. PPACA changes to the Medicare Part D benefit that are effective for the 2011 plan year include the implementation of the gap discount program under which participating manufacturers fund discounts of 50% on brand drugs obtained during the coverage gap or "donut hole," starting the phase-out of the coverage gap for generic drugs (to be completed by 2020), allowing Medicare Part D plans that bid a "*de minimis*" amount above the low-income subsidy ("LIS") benchmark to absorb the cost of the difference between their bid and the LIS benchmark in order to avoid reassignment of their LIS enrollees, simplification of election periods for Medicare

Parts C and D, reducing the premium subsidy for higher-income beneficiaries, extending complaint tracking and reporting, and simplifying the appeals process for enrollees. PPACA also requires the Secretary of HHS to develop rules for shorter dispensing periods for enrollees in long-term care ("LTC") facilities in order to reduce waste beginning in 2012 and new disclosure requirements are expected to be implemented in 2012. HHS issued proposed regulations in November 2010 that would, among other things, require dispensing of brand medications to enrollees in LTC facilities in no greater than 7-day increments at a time and require additional reporting by Medicare Part D plans on dispensing methodologies and unused prescriptions returned to stock by LTC pharmacies. Several of the PPACA changes will require significant adjudication and reporting systems modifications.

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 was signed into law on October 3, 2008, and an interim final rule implementing the law was issued on February 2, 2010. Compliance is required for plan years beginning on or after July 1, 2010. The law requires 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 regulation contains a special rule allowing for "multi-tiered prescription drug benefits" that meet certain conditions, there is considerable uncertainty regarding the application of the 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 differentials between mail service and retail pharmacy providers. In addition, under Medicare Part D, CMS requires that if a Part D sponsor offers a 90-day supply at mail, it must allow retail 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 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 National Association of Insurance Commissioners ("NAIC") have issued model regulations or may propose future regulations concerning PBMs and/or PBM activities. Similarly, credentialing organizations such as NCQA 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 Licensure and Regulation - We are subject to state and federal statutes and regulations governing the operation of retail and mail pharmacies, repackaging of drug products, wholesale distribution, dispensing of controlled substance and listed chemical products, and medical and controlled substance waste disposal. Federal statutes and regulations govern the labeling, packaging, advertising and adulteration of prescription drugs and the dispensing of controlled substances. 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. See Item 3, "Legal Proceedings" for further information.

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 has statutory authority to restrict the transmission of drugs and medicines through the mail, and state licensing authorities may restrict the types of personnel who may work in mail service operations.

Our pharmacists and technicians are subject to state regulation of the profession of pharmacy, and our employees who are engaged in a professional practice must satisfy applicable state licensing or registration requirements and

comply with applicable professional standards. Failure to comply with these regulations could subject us and our employees to disciplinary action, including fines, and 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 PPACA 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 February 2009, Congress enacted the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), as part of ARRA. During 2010, OCR promulgated new and updated non-final regulations in response to the HITECH Act. The HITECH Act contains significant changes to the HIPAA Privacy and Security Rules, which these regulations began to address. These include new restrictions on the use of PHI without an individual's written authorization, a new requirement to account for routine disclosures of PHI held in an electronic health record, a requirement to notify individuals of breaches to their PHI, new 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. While some of the provision of the HITECH Act are already in effect, final regulations regarding the HIPAA privacy, security, enforcement and data breach rules are expected to be issued by OCR early in 2011. Since the rules implementing much of the HITECH Act have not yet been finalized, we cannot at this time determine the 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 invoicing PII.

In addition to HIPAA and HITECH, the Genetic Information Nondiscrimination Act ("GINA") was signed into law on May 21, 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.

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. 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 PPACA.

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 has indicated that it intends to discontinue the publishing of AWP altogether in September 2011. Although Medi-Span has indicated that it intends to continue publishing AWP, we believe the pharmaceutical industry will be evaluating and/or developing 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 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. PPACA 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.

PPACA made several other significant changes to the Medicaid rebates and reimbursement. One of these was to revise the definition of AMP and the reimbursement formula for multi-source (i.e., generic) drugs. CMS has not

yet issued regulations implementing these changes. Therefore, we cannot predict the effect of these changes on Medicaid reimbursement or their impact on the Company. Another significant PPACA change was to require brand and generic manufacturers to pay rebates for product dispensed to beneficiaries enrolled in Medicaid MCOs similar to the way rebates are now required for Medicaid fee-for-service ("FFS") beneficiaries beginning in 2010. Medicaid MCOs are not prohibited from negotiating with manufacturers for rebates above Medicaid's statutory rebates. However, the expansion of the federal Medicaid rebate program to Medicaid MCOs has generally resulted in a reduction of the rebates that manufacturers are willing to pay to the Medicaid MCOs and a reduction of the rebates we receive under our rebate agreements on behalf of our Medicaid MCO clients.

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. 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 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 also 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 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, PPACA 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. As part of PPACA, Congress established a new temporary early retiree reinsurance program providing reimbursement to employer and union sponsors of participating employment-based plans for a portion of the cost of health benefits for early retirees aged 55 to 64 and their spouses, surviving spouses, and dependents. The program reimburses sponsors for certain claims between $15,000 and $90,000. Congress appropriated funding of $5 billion for this temporary program, which became effective June 1, 2010. The program ends when the funding is exhausted, but no later than January 1, 2014.

Safety Regulation - 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, apply to our operations. Any failure to comply with these regulations could result in fines 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 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 prescription drug plans and our PBM service contracts, including those in which we assume certain risk under performance guaranties 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.

Our SilverScript and Accendo PDPs 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. Both SilverScript and Accendo are licensed in all states in which they offer PDPs and do not operate under any Medicare Part D waivers. As licensed insurance companies, SilverScript and Accendo and their agents 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 are 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 have also received permission from CMS to auto-assign their enrollees that do not choose their own Medicare Part D plans into PDPs.

Telemarketing and Other Outbound Calls - 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 calls. These laws may require disclosures of specific information, prohibit misrepresentations, limit when consumers may be called, require consumer consent prior to being called, 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 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 or the pharmacy services or retail industry; (iii) pending or future federal or state governmental investigations of our business or the pharmacy services or retail industry; (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 or retail industry.

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 Securities and Exchange Commission 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. These risks include those described below and may include 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 could adversely affect our business and our financial results.

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.

In that regard, the economic recession resulted in declining drug utilization trends which continued into 2010. Although a recovery might be underway, it is possible that a worsening of the economic environment will cause further decline in drug utilization, and dampen demand for pharmacy benefit management services as well as consumer demand for products sold in our retail stores. If this were to occur, our business and financial results could be adversely affected.

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.

Inability to fully realize the benefits of our fully integrated pharmacy services model.

We may not be able to achieve all of the anticipated long-term strategic benefits of the March 2007 Caremark merger. An inability to realize the full extent of, or any of the anticipated benefits could have an adverse effect on our business, financial position and results of operations, which may affect the value of the shares of our common stock.

Risks relating to the pending acquisition of UAC's Medicare Part D business

In December 2010, the Company announced it had entered into an agreement to acquire the Medicare Part D business of UAC for approximately $1.25 billion. The transaction is subject to customary closing conditions, including necessary regulatory approvals, as well as approval by UAC shareholders. The Company currently expects that the transaction will close by the end of the second quarter of 2011. In the event the closing is delayed or does not occur and/or the regulatory review process materially alters the terms of the acquisition, the Company may not be able to realize the expected benefits of the transaction.

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

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. 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 affect health care financing and reimbursement practices. If the current health care financing and reimbursement system changes significantly, the Company's business, financial position and results of operations could be materially adversely affected.

PPACA made several significant changes to Medicaid rebates and reimbursement. One of these changes was to revise the definition of AMP and the reimbursement formula for multi-source drugs. CMS has not yet issued regulations implementing these changes. Therefore, we cannot predict the effect these changes will have on Medicaid reimbursement or their impact on the Company. In addition, PPACA 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 PPACA 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 may adversely affect our business, financial position and results of operations.

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. Although none of our PBM clients represented more than 10% of our Company's consolidated revenues in 2010, our top 10 clients are expected to represent approximately 21% of such revenues in 2011. 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. Our failure to renew or win PBM business could adversely affect our business, financial position and results of operations.

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, 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) could adversely affect our business, financial position and results of operations.

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 Caremark 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. Accordingly, margin pressure in the PBM industry resulting from these trends could adversely affect our business, financial position and results of operations.

Regulatory and business changes relating to our participation in Medicare Part D may adversely affect our business, financial position and our results of operations.

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 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 Medicare Part D may outweigh any opportunities for new business generated by the new benefit. 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; 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 materially and adversely affected, and our business, financial position and results of operations may be adversely affected.

Changes in industry pricing benchmarks could adversely affect our business, financial position and results of operations.

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 has indicated that it intends to discontinue the publishing of AWP altogether in September 2011. Although Medi-Span has indicated that it intends to continue publishing AWP for the foreseeable future, we believe the pharmaceutical industry will be evaluating and/or developing 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.

The industries in which we operate are extremely competitive and competition could adversely affect our business, financial position and results of operations.

Each of the retail pharmacy business and the PBM business currently operates in a highly competitive environment. 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). 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. As a result, competition could have an adverse effect on our business, financial position and results of operations.

Competitors in the PBM industry include large national PBM companies, such as Medco Health Solutions, Inc. and Express Scripts, Inc., as well as many local or regional PBMs. In addition, there are several large health insurers and managed care plans (e.g., United Healthcare and CIGNA) and retail pharmacies which have their own PBM capabilities as well as several other national and regional companies that provide some or all of the same services. 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. As a result, competition could have an adverse effect on our business, financial position and results of operations.

Reform of the U.S. health care system may adversely affect our financial performance and the services we provide.

Congressional efforts to reform the U.S. health care system finally came to fruition in 2010 with the passage of PPACA, which will bring about the most significant structural changes to the health insurance system in decades. While the bulk of the structural changes enacted by PPACA will not be implemented until 2014, and some of the key changes, such as the individual mandate, are already being challenged at the judicial and legislative levels, it is expected that there will be increased government involvement in health care and regulation of PBM or pharmacy services. This may change the way the Company or its clients do business. Health plan sponsors may react to these changes and the uncertainty surrounding them by reducing or delaying purchases of cost control mechanisms and related services that the Company would provide. The Company cannot predict what effect, if any, the PPACA changes may have on its retail and pharmacy services businesses. Other legislative or market-

driven changes in the health care system that the Company cannot anticipate could also have an adverse effect on our business, financial position and results of operations.

Our inability to comply with a broad and complex regulatory framework could adversely affect our business, financial position and results of operations.

The PBM business and retail drugstore business are 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 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 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; 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. We are also subject to the terms of the government agreements 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 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 named and generic drugs, or of over-the-counter status for brand name drugs;
- FDA regulation affecting the retail or PBM industry;
- 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; 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. Resolution of these matters could have a material adverse effect on our business and results of operations. 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, on pages 41 through 42 of our Annual Report to Stockholders for the year ended December 31, 2010, 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” on page 65 in our Annual Report to Stockholders for the year ended December 31, 2010, which section is incorporated by reference herein.

As of December 31, 2010, we owned approximately 5.0% of our 7,182 retail stores. Net selling space for our retail drugstores increased to 69.7 million square feet as of December 31, 2010. More than one half of our store base was opened or significantly remodeled within the last five years.

We own nine distribution centers located in Alabama, California, Hawaii, Rhode Island, South Carolina, Tennessee and Texas and lease ten additional facilities located in Arizona, Florida, Indiana, Michigan, New Jersey, Pennsylvania, Rhode Island, Texas and Virginia. The 19 distribution centers total approximately 10.7 million square feet as of December 31, 2010. In addition, during 2009, we began construction on two new distribution centers, one in Chemung County, New York, and one in Kapolei, Hawaii, each of which is expected to open during 2011.

As of December 31, 2010, we owned one mail service pharmacy located in Texas and leased three additional mail service pharmacies located in Florida, Illinois and Pennsylvania. We leased call centers located in Missouri, Pennsylvania, Tennessee, Texas and Puerto Rico. As of December 31, 2010, we also had 18 specialty mail order pharmacies, one of which we owned, and 44 specialty pharmacy stores, which we leased. The specialty mail order pharmacies and specialty pharmacy stores are located in 25 states, the District of Columbia and Puerto Rico. In addition, we lease a central fill facility in Sacramento, California.

We own our corporate offices located in Woonsocket, Rhode Island, which totals approximately 750,000 square feet. We are currently in the process of expanding our corporate offices in the State of Rhode Island. 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 70 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 the Note “Commitments and Contingencies” on page 74 in our Annual Report to Stockholders for the year ended December 31, 2010, 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.

Following is a breakdown by state, District of Columbia and Puerto Rico of our retail and specialty pharmacy stores as well as our specialty mail order pharmacy locations as of December 31, 2010:

	Retail Stores	Retail Specialty Pharmacy Stores	Specialty Mail Order Pharmacies	Total
Alabama	150	1	—	151
Arizona	132	1	—	133
California	827	5	1	833
Colorado	—	1	—	1
Connecticut	137	—	—	137
Delaware	5	—	—	5
District of Columbia	57	1	—	58
Florida	708	3	1	712
Georgia	307	1	—	308
Hawaii	48	1	—	49
Iowa	10	—	—	10
Illinois	261	1	1	263
Indiana	290	—	—	290
Kansas	31	—	1	32
Kentucky	59	—	—	59
Louisiana	99	—	1	100
Maine	22	—	—	22
Maryland	166	—	2	168
Massachusetts	339	13	1	353
Michigan	243	—	1	244
Minnesota	42	—	1	43
Mississippi	43	—	—	43
Missouri	54	1	—	55
Montana	13	—	—	13
Nebraska	7	—	—	7
Nevada	85	—	—	85
New Hampshire	34	—	—	34
New Jersey	263	—	1	264
New Mexico	9	—	—	9
New York	445	4	—	449
North Carolina	303	1	1	305
North Dakota	6	—	—	6
Ohio	313	—	—	313
Oklahoma	42	—	—	42
Oregon	—	1	—	1
Pennsylvania	384	1	1	386
Puerto Rico	9	—	1	10
Rhode Island	58	2	—	60
South Carolina	192	1	—	193
Tennessee	126	1	1	128
Texas	524	3	2	529
Vermont	3	—	—	3
Virginia	254	—	—	254
Washington	—	1	1	2
West Virginia	50	—	—	50
Wisconsin	32	—	—	32
	7,182	44	18	7,244

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. The parties previously filed cross motions for partial summary judgment, and in August 2008, the court granted several of Caremark's motions and denied the motions filed by the plaintiffs. The court's rulings are favorable to Caremark and substantially limit the ability of the plaintiffs to assert false claims act allegations or statutory or common law theories of recovery based on Caremark's processing of Medicaid and other government reimbursement requests. The court's rulings are on appeal before the United States Court of Appeals for the Fifth Circuit. 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 our processing of Texas Medicaid claims on behalf of PBM clients. The claims and issues raised in this lawsuit are related to the claims and issues pending in the federal qui tam lawsuit described above.

2. In December 2007, the Company received a document subpoena from the OIG, requesting information relating to the processing of Medicaid and other government agency claims on a different adjudication platform of Caremark. 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 this OIG subpoena 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 of Caremark's adjudication platforms. The Company has been producing documents on a rolling basis in response to the requests for information contained in the OIG subpoena and in these civil investigative demands. The Company cannot predict with certainty the timing or outcome of any review of such information.

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. The attorneys and law firms named as defendants in McArthur's intervention pleadings have been dismissed from the case, and discovery on class certification and adequacy issues is underway.

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 the 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. 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. Beginning in November 2008, the Company received and responded to several subpoenas from the DEA, Los Angeles Field Division, requesting sales data and other information regarding the Company's distribution of products containing pseudoephedrine ("PSE") at certain retail pharmacies and from one California distribution center. In September 2009, the United States Attorney's Office for the Central District of California ("USAO") and the DEA commenced discussions with the Company regarding whether, in late 2007 and 2008, the Company distributed PSE in violation of the Controlled Substances Act. In addition, the DEA issued an order to show cause against certain retail pharmacies and the Company's La Habra, California distribution center which could have resulted in administrative action against the Company's DEA registrations for these facilities. On October 13, 2010, the Company entered into a comprehensive resolution of this matter, resulting in the payment of $75 million in civil penalties for violations of the Controlled Substances Act and $2.6 million in criminal forfeiture relating to the sales of products containing PSE. The resolution included the entry of a non-prosecution agreement and civil settlement agreement with the USAO, the U.S. Attorney's Office for the District of Nevada and the DOJ, as well as a memorandum of agreement with the DEA that dismisses the above-referenced orders to show cause and contains certain ongoing compliance requirements for the Company.

6. In August 2009, the Company was notified by the FTC that it is conducting a non-public investigation under the FTCA into certain of the Company's business practices. In March 2010, the Company learned that various State Attorneys General offices and certain other government agencies are conducting a multi-state investigation of the Company regarding issues similar to those being investigated by the FTC. At this time, 24 states, the District of Columbia, and the County of Los Angeles, are known to be participating in this multi-state investigation. The Company has been cooperating in these investigations, and continues to provide documents and other information as requested. The Company is not able to predict with certainty the timing or outcome of these investigations. However, it remains confident that its business practices and service offerings (which are designed to reduce health care costs and expand consumer choice) are being conducted in compliance with the antitrust laws.

7. In March 2009, the Company received a subpoena from the OIG requesting information concerning the Medicare Part D prescription drug plans of RxAmerica, the PBM subsidiary of Longs Drug Stores Corporation which was acquired by the Company in October 2008. The Company continues to respond to the request for information and has been producing responsive documents on a rolling basis. The Company cannot predict with certainty the timing or outcome of any review by the government of such information.

8. Since March 2009, the Company has been named in a series of putative collective and class action lawsuits filed in federal courts around the country, purportedly on behalf of current and former assistant store managers working in the Company's stores at various locations outside California. The lawsuits allege that the Company failed to pay overtime to assistant store managers as required under the Fair Labor Standards Act ("FLSA") and under certain state statutes. The lawsuits also seek other relief, including liquidated

damages, punitive damages, attorneys' fees, costs and injunctive relief arising out of the state and federal claims for overtime pay. Notice has been issued to over 13,000 current and former assistant store managers offering them the opportunity to "opt in" to certain of the FLSA collective actions and over 1,900 have elected to participate in these lawsuits. At this time, the Company is not able to predict the outcome of these cases, or the possible monetary exposure associated with the lawsuits. The Company's position, however, that the lawsuits are without merit and that the cases should not be certified as class or collective actions. The Company is vigorously defending these claims.

9. In January 2010, the Company received a subpoena from the OIG in connection with an investigation of possible false or otherwise improper claims for payment under the Medicare and Medicaid programs. The subpoena requests retail pharmacy claims data for "dual eligible" customers (i.e., customers with both Medicaid and private insurance coverage), information concerning the Company's retail pharmacy claims processing systems, copies of pharmacy payor contracts and other documents and records. The Company has provided documents and other information in response to the subpoena and continues to engage in discussions with the government about the subject matter of the subpoena. The Company cannot predict with certainty the timing or outcome of any review by the government of such information.

10. 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 continues to respond to this request for information and has been producing responsive documents on a rolling basis. We cannot predict with certainty the timing or outcome of any reviews by the government of such information.

11. 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 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. The Company believes these lawsuits are without merit and the Company plans to defend them vigorously.

12. 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 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, as they may relate to our business or the pharmacy services or retail industry; (iii) pending or future federal or state governmental investigations of our business or the pharmacy services or retail industry; (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 or retail industry.

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 October 22, 2010, the Company entered into a Consent Order with the State of Connecticut to address alleged noncompliance with state wastewater discharge regulations and related notices of violation issued with respect to certain of its stores in Connecticut. As part of the negotiated Order, the Company has agreed to make certain operational changes with respect to its wastewater discharges from stores within the state. In addition, the Company funded a supplemental environmental project in the amount of $45,000 and paid a $223,900 civil penalty to resolve the allegations in the Order. Negotiations remain ongoing with the State of Connecticut regarding additional environmental compliance matters unrelated to wastewater discharge. The Company cannot predict the ultimate outcome of these negotiations; however, management does not believe that the outcome will have a material adverse effect on the Company.

2. The Company has also received notices of violation and information requests from governmental authorities in California, and is currently working with several local governments regarding statewide compliance with environmental regulations governing the management of hazardous waste. The resolution of these issues may require payment of civil penalties, and operational changes within stores in California. The ultimate outcome of these matters cannot be determined at this time.

Item 4. Submission of Matters to a Vote of Security Holders

No matters were submitted to a vote of security holders during the three months ended December 31, 2010.

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 18, 2011. 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 54, 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 56, 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.

Laird K. Daniels, age 42, Senior Vice President and Controller/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; Assistant Controller, Budgeting, Forecasting and Reporting of CVS Pharmacy, Inc. from June 2003 through October 2006.

David M. Denton, age 45, Executive Vice President and Chief Financial Officer of CVS Caremark Corporation and CVS Pharmacy, Inc. 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; Senior Vice President, Finance and Controller of PharmaCare Management Services, Inc. from October 2005 through April 2007.

Sara J. Finley, age 50, Senior Vice President and General Counsel of CVS Caremark since June 2009; Executive Vice President and General Counsel of Caremark from March 2009 through June 2009; Senior Vice President and General Counsel of Caremark from March 2007 through March 2009; Senior Vice President, Assistant General Counsel and Corporate Secretary of Caremark from August 1998 through March 2007.

Helena B. Foulkes, age 46, Executive Vice President and Chief Marketing Officer of CVS Caremark Corporation since January 2009; 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; Senior Vice President, Marketing and Operations Services of CVS Pharmacy, Inc. from January 2007 through October 2007, and Senior Vice President, Advertising and Marketing of CVS Pharmacy, Inc. from April 2002 to January 2007.

Per G.H. Lofberg, age 63, Executive Vice President of CVS Caremark Corporation and President of Caremark Pharmacy Services since January 2010; 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.

Stuart M. McGuigan, age 52, Senior Vice President and Chief Information Officer of CVS Caremark Corporation since January 2009 and Senior Vice President and Chief Information Officer of CVS Pharmacy, Inc.

since December 2008; Senior Vice President and Chief Information Officer of Liberty Mutual Group from September 2004 to November 2008; also a director of NetScout Systems, Inc., a leading provider of integrated network and application performance management solutions.

Larry J. Merlo, age 55, President and Chief Operating Officer of CVS Caremark Corporation since May 2010 and President of CVS/pharmacy since January 2007; 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. Mr. Merlo will become President and Chief Executive Officer of CVS Caremark Corporation on March 1, 2011.

Jonathan C. Roberts, age 55, Executive Vice President of CVS Caremark Corporation and Chief Operating Officer of Caremark Pharmacy Services since October 2010; 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; Senior Vice President—Store Operations of CVS Pharmacy, Inc. from August 2002 until December 2005.

Thomas M. Ryan, age 58, Chairman of the Board of CVS Caremark Corporation since November 2007 and Chief Executive Officer of CVS Caremark Corporation since May 1998; President of CVS Caremark Corporation from May 1998 through May 2010 and Chairman of CVS Corporation from April 1999 until March 2007; also a director of Yum! Brands, Inc., a quick service restaurant company. Mr. Ryan will retire as Chief Executive Officer on March 1, 2011 and will serve as non-executive Chairman of the Board until the Company's Annual Meeting of Stockholders in May 2011, at which time he will retire from the Board.

Douglas A. Sgarro, age 51, Executive Vice President and Chief Legal Officer of CVS Caremark Corporation and CVS Pharmacy, Inc. since March 2004; President of CVS Realty Co., a real estate development company and a division of CVS Pharmacy, Inc., from October 1999 though 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
2010	High	$ 37.32	$ 37.82	$ 32.09	$ 35.46	$ 37.82
	Low	$ 30.36	$ 29.22	$ 26.84	$ 29.45	$ 26.84
	Cash dividends per common share	$ 0.08750	$ 0.08750	$ 0.08750	$ 0.08750	$ 0.35000
2009	High	$ 30.47	$ 34.22	$ 37.75	$ 38.27	$ 38.27
	Low	$ 23.74	$ 27.08	$ 30.58	$ 27.38	$ 23.74
	Cash dividends per common share	$ 0.07625	$ 0.07625	$ 0.07625	$ 0.07625	$ 0.30500

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 11, 2011, there were 22,111 registered shareholders according to the records maintained by our transfer agent.

During the first three quarters of 2010, we repurchased 42.4 million shares of common stock for approximately $1.5 billion completing the repurchase program authorized during 2009. On June 14, 2010, our Board of Directors authorized a new share repurchase program for up to $2.0 billion of our outstanding common stock (the "2010 Repurchase Program"). The share repurchase authorization, which was effective immediately and expires at the end of 2011, 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. The share repurchase program may be modified, extended or terminated by the Board of Directors at any time. The Company did not make any share repurchases under the 2010 Repurchase Program through December 31, 2010.

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, 2010 through October 31, 2010	—	$ —	—	$ 2,000,000
November 1, 2010 through November 30, 2010	—	$ —	—	$ 2,000,000
December 1, 2010 through December 31, 2010	—	$ —	—	$ 2,000,000

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, 2010 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	2010[2]	2009[2]	2008[2]	2007[2] [3]	2006[2]
Statement of operations data:					
Net revenues	$ 96,413	$ 98,729	$ 87,472	$ 76,330	$ 43,821
Gross profit	20,257	20,380	18,290	16,108	11,742
Operating expenses[4]	14,092	13,942	12,244	11,314	9,300
Operating profit[5]	6,165	6,438	6,046	4,794	2,442
Interest expense, net	536	525	509	435	216
Income tax provision[6]	2,190	2,205	2,193	1,722	857
Income from continuing operations	3,439	3,708	3,344	2,637	1,369
Loss from discontinued operations, net of income tax benefit[7]	(15)	(12)	(132)	—	—
Net income	3,424	3,696	3,212	2,637	1,369
Net loss attributable to noncontrolling interest[1]	3	—	—	—	—
Preference dividends, net of income tax benefit	—	—	(14)	(14)	(14)
Net income attributable to CVS Caremark	$ 3,427	$ 3,696	$ 3,198	$ 2,623	$ 1,355
Per common share data:					
Basic earnings per common share:					
Income from continuing operations attributable to CVS Caremark	$ 2.52	$ 2.59	$ 2.32	$ 1.97	$ 1.65
Loss from discontinued operations attributable to CVS Caremark	(0.01)	(0.01)	(0.09)	—	—
Net income attributable to CVS Caremark	$ 2.51	$ 2.58	$ 2.23	$ 1.97	$ 1.65
Diluted earnings per common share:					
Income from continuing operations attributable to CVS Caremark	$ 2.50	$ 2.56	$ 2.27	$ 1.92	$ 1.60
Loss from discontinued operations attributable to CVS Caremark	(0.01)	(0.01)	(0.09)	—	—
Net income attributable to CVS Caremark	$ 2.49	$ 2.55	$ 2.18	$ 1.92	$ 1.60
Cash dividends per common share	$ 0.35000	$ 0.30500	$ 0.25800	$ 0.22875	$ 0.15500
Balance sheet and other data:					
Total assets	$ 62,169	$ 61,641	$ 60,960	$ 54,722	$ 20,574
Long-term debt	$ 8,652	$ 8,756	$ 8,057	$ 8,350	$ 2,870
Total shareholders' equity	$ 37,700	$ 35,768	$ 34,574	$ 31,322	$ 9,918
Number of stores (end of year)	7,226	7,074	6,981	6,301	6,205

(1) Represents the minority shareholders' portion of the net loss from our majority owned subsidiary Generation Health, Inc. acquired in the fourth quarter of 2009.

(2) 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 fiscal 2010 and 2009 include 365 days; fiscal 2008 includes 368 days, and fiscal 2007 and 2006 include 364 days.

(3) Effective March 22, 2007, Caremark Rx, Inc. was merged into a newly formed subsidiary of CVS Corporation, with Caremark Rx, L.L.C., continuing as the surviving entity (the "Caremark Merger"). Following the Caremark Merger, the name of the Company was changed to "CVS Caremark Corporation." By virtue of the Caremark Merger, each issued and outstanding share of Caremark common stock, par value $0.001 per share, was converted into the right to receive 1.67 shares of CVS Caremark's common stock, par value $0.01 per share. Cash was paid in lieu of fractional shares.

(4) In 2006, the Company adopted the SEC Staff Accounting Bulletin ("SAB") No. 108, "Considering the Effects of Prior Year Misstatements when Qualifying Misstatements in Current Year Financial Statements." The adoption of this SAB resulted in a $40 million pre-tax ($25 million after-tax) decrease in operating expenses for 2006.

(5) Operating profit includes the pre-tax effect of the charge discussed in Note (4) above.

(6) 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, and (iii) in 2006, a $11 million reversal of previously recorded tax reserves through the tax provision principally based on resolving certain state tax matters.

(7) In connection with certain business dispositions completed between 1991 and 1997, the Company continues to guarantee store lease obligations for a number of former subsidiaries, including Linens 'n Things. On May 2, 2008, Linens Holding Co. and certain affiliates, which operate Linens 'n Things, filed voluntary petitions under Chapter 11 of the United States Bankruptcy Code in the United States Bankruptcy Court for the District of Delaware. The loss from discontinued operations includes lease-related costs of $15 million ($24 million, net of a $9 million income tax benefit), $12 million ($19 million, net of an $7 million income tax benefit), and $132 million ($214 million, net of an $82 million income tax benefit) in 2010, 2009 and 2008 respectively, which the Company believes is likely to be required to satisfy its obligations associated with its Linens 'n Things lease guarantees.

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, on pages 44 through 45 of our Annual Report to Stockholders for the year ended December 31, 2010, which section is incorporated by reference herein.

Item 7A. Quantitative and Qualitative Disclosures about Market Risk

As of December 31, 2010, 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," on pages 53 through 80, and "Report of Independent Registered Public Accounting Firm" on page 83 of our Annual Report to Stockholders for the fiscal year ended December 31, 2010, 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, 2010, 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" on page 46 and "Report of Independent Registered Public Accounting Firm" on page 47 of our Annual Report to Stockholders for the fiscal year ended December 31, 2010, 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, 2010 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 and Executive Officers of the Registrant

We refer you to our Proxy Statement for the 2011 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 2011 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 2011 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, 2010.

	Number of securities to be issued upon exercise of outstanding options, warrants and rights	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]	66,017	$ 31.39	71,899
Equity compensation plans not approved by stockholders	—	—	—
Total	66,017	$ 31.39	71,899

(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 either the 2010 ICP or a predecessor plan are cancelled or forfeited; in such event the shares shall again be available for grants or awards.

Item 13. Certain Relationships and Related Transactions and Director Independence

We refer you to our Proxy Statement for the 2011 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 2011 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, Financial Statement Schedules

A. Documents filed as part of this report:

1. Financial Statements:

The following financial statements are incorporated by reference from pages 20 through 80 and page 83 of our Annual Report to Stockholders for the fiscal year ended December 31, 2010, 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
1.1*	Underwriting Agreement dated September 5, 2008 by and among the Registrant and Lehman Brothers Inc., Banc of America Securities LLC, Deutsche Bank Securities Inc., Morgan Stanley & Co. Incorporated and Wachovia Capital Markets, LLC, as Representatives of the Underwriters [incorporated by reference to Exhibit 1.1 to the Registrant's Current Report on Form 8-K dated September 5, 2008 (Commission File No. 001-01011)].
1.2*	Underwriting Agreement dated March 10, 2009 by and among the Registrant and Barclays Capital Inc., Banc of America Securities LLC, Deutsche Bank Securities Inc., Morgan Stanley & Co. Incorporated and Wachovia Capital Markets, LLC, as Representatives of the Underwriters [incorporated by reference to Exhibit 1.1 to the Registrant's Current Report on Form 8-K dated March 13, 2009 (Commission File No. 001-01011)].
1.3*	Underwriting Agreement dated September 8, 2009 by and among the Registrant and Barclays Capital Inc., Banc of America Securities LLC, BNY Mellon Capital Markets, LLC, JP Morgan Securities Inc. and Wells Fargo Securities, LLC, as Representatives of the Underwriters [incorporated by reference to Exhibit 1.1 to the Registrant's Current Report on Form 8-K dated September 11, 2009 (Commission File No. 001-01011)].
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].

Exhibit	Description
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)].
3.2*	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 December 29, 2010 (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)].

Exhibit	Description
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*	2007 Incentive Plan, as amended and restated through December 2008 [incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 (Commission File No. 001-01011)].
10.12*	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].
10.13*	Caremark Rx, Inc. Deferred Compensation Plan, effective April 1, 2005, as amended and restated through December 2008 [incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 (Commission File No. 001-01011)].

Exhibit	Description
10.14*	CVS Caremark Deferred Compensation Plan as amended and restated through December 2008 [incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 (Commission File No. 001-01011)].
10.15*	CVS Partnership Equity Program [incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the quarter ended June 27, 1998 (Commission File No. 001-01011)].
10.16*	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)].
10.17*	Retention Agreement dated as of August 5, 2005 between the Registrant and the Registrant's Chief Executive Officer [incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the quarterly period ended October 1, 2005 (Commission File No. 001-01011)].
10.18*	Form of Restricted Stock Unit Agreement between the Registrant and the Registrant's Chief Executive Officer [incorporated by reference to Exhibit 10.3 to the Registrant's Quarterly Report on Form 10-Q for the quarterly period ended October 1, 2005 (Commission File No. 001-01011)].
10.19*	Five Year Credit Agreement dated as of May 12, 2006 by and among the Registrant, the lenders party thereto, Bank of America, N.A., Lehman Brothers Inc. and Wachovia Bank, N.A., as Co-Syndication Agents, Keybank N.A., as Documentation Agent, and The Bank of New York, as Administrative Agent [incorporated by reference to Exhibit 10.4 to the Registrant's Current Report on Form 8-K dated June 2, 2006 (Commission File No. 001-01011)].
10.20*	Amended and Restated Employment Agreement dated as of December 22, 2008 between the Registrant and the Registrant's Chairman of the Board and Chief Executive Officer [incorporated by reference to Exhibit 10.36 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2008 (Commission File No. 001-01011)].
10.21*	Amended and Restated Employment Agreement dated as of December 22, 2008 between the Registrant and the Registrant's President and Chief Operating 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)].
10.22*	Amended and Restated Employment Agreement dated as of December 22, 2008 between the Registrant and the Registrant's Executive Vice President and Chief Legal 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, 2008 (Commission File No. 001-01011)].
10.23*	Five Year Credit Agreement dated as of March 12, 2007 by and among the Registrant, the lenders party thereto, Lehman Commercial Paper Inc., and Wachovia Bank, N.A., as Co-Syndication Agents, Morgan Stanley Senior Funding, Inc. as Documentation Agent, and the Bank of New York, as Administrative Agent [incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K dated March 22, 2007 (Commission File No. 001-01011)].
10.24*	Bridge Credit Agreement dated as of March 15, 2007 by and among the Registrant, the lenders party thereto, Lehman Commercial Paper Inc., as Administration Agent, Morgan Stanley Senior Funding, Inc., as Syndication Agent, The Bank of New York, Bank of America, N.A. and Wachovia Bank, N.A., as Co-Documentation Agents [incorporated by reference to Exhibit 10.3 to the Registrant's Current Report on Form 8-K dated March 22, 2007 (Commission File No. 001-01011)].
10.25*	Global Amendment dated as of March 15, 2007, to (i) Five Year Credit Agreement dated as of June 11, 2004, (ii) Five Year Credit Agreement dated as of June 2, 2005, (iii) Five Year Credit Agreement dated as of May 12, 2006, (iv) Five Year Credit Agreement, dated as of March 12, 2007, and (v) 364 Day Credit Agreement, dated as of March 12, 2007 [incorporated by reference to Exhibit 10.4 to the Registrant's Current Report on Form 8-K dated March 22, 2007 (Commission File No. 001-01011)].

Exhibit

Exhibit	Description
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, 2010 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 18, 2011

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/ EDWIN M. BANKS **Edwin M. Banks**	Director	February 18, 2011
/s/ C. DAVID BROWN II **C. David Brown II**	Director	February 18, 2011
/s/ LAIRD K. DANIELS **Laird K. Daniels**	Senior Vice President – Finance and Controller (Principal Accounting Officer)	February 18, 2011
/s/ DAVID M. DENTON **David M. Denton**	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 18, 2011
/s/ DAVID W. DORMAN **David W. Dorman**	Director	February 18, 2011
/s/ ANNE M. FINUCANE **Anne M. Finucane**	Director	February 18, 2011
/s/ KRISTEN GIBNEY WILLIAMS **Kristen Gibney Williams**	Director	February 18, 2011
/s/ MARIAN L. HEARD **Marian L. Heard**	Director	February 18, 2011
/s/ WILLIAM H. JOYCE **William H. Joyce**	Director	February 18, 2011
/s/ LARRY J. MERLO **Larry J. Merlo**	Director	February 18, 2011

Signature	Title(s)	Date
/s/ JEAN-PIERRE MILLON **Jean-Pierre Millon**	Director	February 18, 2011
/s/ TERRENCE MURRAY **Terrence Murray**	Director	February 18, 2011
/s/ C.A. LANCE PICCOLO **C.A. Lance Piccolo**	Director	February 18, 2011
/s/ SHELI Z. ROSENBERG **Sheli Z. Rosenberg**	Director	February 18, 2011
/s/ THOMAS M. RYAN **Thomas M. Ryan**	Chairman of the Board and Chief Executive Officer (Principal Executive Officer)	February 18, 2011
/s/ RICHARD J. SWIFT **Richard J. Swift**	Director	February 18, 2011

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 pharmacy health care provider in the United States. As a fully integrated pharmacy services company, we believe we can drive value for our customers by effectively managing pharmaceutical costs and improving health care outcomes through our pharmacy benefit management, mail order and specialty pharmacy division, CVS Caremark Pharmacy Services® ("Caremark"); our approximately 7,200 CVS/pharmacy® retail stores; our retail-based health clinic subsidiary, MinuteClinic®; and our online pharmacy, CVS.com®. The Company has three business segments: Pharmacy Services, Retail Pharmacy and Corporate.

Overview of Our Pharmacy Services Segment

Our Pharmacy Services business provides a full range of pharmacy benefit management ("PBM") services including mail order pharmacy services, specialty pharmacy services, plan design and administration, formulary management and claims processing. 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 65,000 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.

We also provide health management programs, which include integrated disease management for 28 conditions, through our strategic alliance with Alere, L.L.C. and 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 Accendo Insurance Company ("Accendo") subsidiaries, we are a national provider of drug benefits to eligible beneficiaries under the Federal Government's Medicare Part D program. The Company acquired Accendo in the Longs Acquisition (defined later in this document), and, effective January 1, 2009, Accendo replaced RxAmerica® as the Medicare-approved prescription drug plan for the RxAmerica Medicare Part D drug benefit plans. In December 2010, the Company announced it had entered into an agreement to acquire the Medicare Part D business of Universal American Corp. ("UAC") for approximately $1.25 billion. The transaction is subject to customary closing conditions, including necessary regulatory approvals, as well as approval by UAC shareholders. The Company currently expects that the transaction will close by the end of the second quarter of 2011.

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®, CarePlus™, RxAmerica®, Accordant Care™ and TheraCom® names. As of December 31, 2010, the Pharmacy Services segment operated 44 retail specialty pharmacy stores, 18 specialty mail order pharmacies and four mail service pharmacies located in 25 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 20,000 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.

CVS/pharmacy is one of the nation's largest retail pharmacy chains. With more than 40 years of dynamic growth in the retail pharmacy industry, the Retail Pharmacy segment generates more than two-thirds of its revenue from prescription sales and is committed to providing superior customer service by being the easiest pharmacy retailer for customers to use.

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 well over 67 million active cardholders, making it one of the largest and most successful retail loyalty card programs in the country.

Effective October 20, 2008, we acquired Longs Drug Stores Corporation, which included 529 retail drug stores (the "Longs Drug Stores"), RxAmerica, LLC ("RxAmerica"), which provides pharmacy benefit management services and, Medicare Part D benefits, and other related assets (the "Longs Acquisition").

As of December 31, 2010, our Retail Pharmacy segment included 7,182 retail drugstores (of which 7,123 operated a pharmacy) located in 41 states, the District of Columbia, and Puerto Rico operating primarily under the CVS/pharmacy or Longs Drugs names, our online retail website, CVS.com and 560 retail health care clinics operating under the MinuteClinic name (of which 550 were located in CVS/pharmacy stores).

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

Fiscal Year Change - On December 23, 2008, the Board of Directors of the Company approved a change in the Company's fiscal year end from the Saturday nearest December 31 of each year to December 31 of each year to better reflect the Company's position in the health care, rather than the retail, industry. The fiscal year change was effective beginning with the fourth quarter of 2008.

As you review our operating performance, please consider the impact of the fiscal year change as set forth below:

Fiscal Year	Fiscal Year-End	Fiscal Period	Fiscal Period Includes
2010	December 31, 2010	January 1, 2010 - December 31, 2010	365 days
2009	December 31, 2009	January 1, 2009 - December 31, 2009	365 days
2008	December 31, 2008	December 30, 2007 - December 31, 2008	368 days

Unless otherwise noted, all references to years relate to the above fiscal years.

Summary of our Consolidated Financial Results

	Fiscal Year		
In millions, except per common share amounts	**2010**	**2009**	**2008**
Net revenues	$96,413	$98,729	$87,472
Gross profit	20,257	20,380	18,290
Operating expenses	14,092	13,942	12,244
Operating profit	6,165	6,438	6,046
Interest expense, net	536	525	509
Income before income tax provision	5,629	5,913	5,537
Income tax provision	2,190	2,205	2,193
Income from continuing operations	3,439	3,708	3,344
Loss from discontinued operations, net of income tax benefit	(15)	(12)	(132)
Net income	3,424	3,696	3,212
Net loss attributable to noncontrolling interest	3	—	—
Preference dividend, net of income tax benefit	—	—	(14)
Net income attributable to CVS Caremark	$ 3,427	$ 3,696	$ 3,198
Diluted earnings per common share:			
Income from continuing operations attributable to CVS Caremark	$ 2.50	$ 2.56	$ 2.27
Loss from discontinued operations attributable to CVS Caremark	(0.01)	(0.01)	(0.09)
Net income attributable to CVS Caremark	$ 2.49	$ 2.55	$ 2.18

Net revenues decreased $2.3 billion in 2010 and increased $11.3 billion in 2009. As you review our performance in this area, we believe you should consider the following important information:

- During 2010, net revenues in our Retail Pharmacy segment increased by 3.6% which was offset by a decline in our Pharmacy Services segment of 6.4%, compared to the prior year. The increase in our generic dispensing rates in both of our operating segments had an adverse effect on net revenue in 2010 as compared to 2009, as well as in 2009 as compared to 2008.

- Three fewer days in the 2009 fiscal year negatively impacted net revenues by $671 million, compared to 2008.
- During 2009, the Longs Acquisition increased net revenues by $6.6 billion, compared to 2008. The results for 2008 includes net revenues from the Longs Drug Stores and RxAmerica from the acquisition date (October 20, 2008) forward.

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

Gross profit decreased $0.1 billion in 2010, to $20.3 billion or 21.0% of net revenues, as compared to 2009. Gross profit increased $2.1 billion in 2009 to $20.4 billion or 20.6% of net revenues, as compared to 2008. As you review our performance in this area, we believe you should consider the following important information:

- During 2010, gross profit in our Retail Pharmacy segment increased by 2.7% offset by declines in our Pharmacy Services segment of 12.6%, compared to the prior year.
- During 2009, the Longs Acquisition increased gross profit dollars by $1.1 billion, but negatively impacted our gross profit rate compared to 2008.
- Three fewer days in the 2009 fiscal year, negatively impacted gross profit by $146 million, compared to 2008.
- The results for 2008 include gross profit from the Longs Drug Stores and RxAmerica from the acquisition date (October 20, 2008) forward.
- In addition, for the three years 2008 through 2010, 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 $151 million and $1.7 billion during 2010 and 2009, respectively. As you review our performance in this area, we believe you should consider the following important information:

- During 2010, operating expenses increased as a result of increases in our Corporate segment expenses of $87 million, and an increase in our Retail Pharmacy segment expenses of $68 million, partially offset by a decrease in our Pharmacy Services segment expenses of $5 million, compared to the prior year.
- During 2009, the Longs Acquisition increased operating expenses by $1.0 billion, but positively impacted our operating expense rate as a percentage of net revenues compared to 2008.
- Three fewer days in the 2009 fiscal year, positively impacted operating expenses by $97 million, compared to 2008.
- The results of 2008 include operating expenses from the Longs Drug Stores and RxAmerica from the acquisition date (October 20, 2008) forward.

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

Interest expense, net consisted of the following:

In millions	2010	2009	2008
Interest expense	$539	$530	$530
Interest income	(3)	(5)	(21)
Interest expense, net	$536	$525	$509

During 2010, net interest expense increased by $11 million, to $536 million compared to 2009, due to an increase in our average debt balances and average interest rates. During 2009, net interest expense increased by $16 million, compared to 2008, due to lower interest income associated with our temporary investments.

Income tax provision - Our effective income tax rate was 38.9% in 2010, 37.3% in 2009 and 39.6% in 2008. The annual fluctuations in our effective income tax rate are primarily related to changes in permanent items, state income tax expense and the recognition of previously unrecognized tax benefits relating to the expiration of various statutes of limitation and settlements with tax authorities. In 2010 we recognized a $47 million income tax benefit related to the expiration of various statutes of limitation and settlements with tax authorities. Similarly, in 2009 we recognized a $167 million income tax benefit relating to the expiration of various statutes of limitation and settlements with tax authorities.

Income from continuing operations decreased $269 million or 7.2% to $3.4 billion in 2010. This compares to $3.7 billion in 2009 and $3.3 billion in 2008. As previously noted, income from continuing operations in 2010 and 2009 both benefited from previously unrecognized tax benefit.

Loss from discontinued operations - In connection with certain business dispositions completed between 1991 and 1997, the Company continues to guarantee store lease obligations for a number of former subsidiaries, including Linens ‘n Things. On May 2, 2008, Linens Holding Co. and certain affiliates, which operate Linens ‘n Things, filed voluntary petitions under Chapter 11 of the United States Bankruptcy Code in the United States Bankruptcy Court for the District of Delaware. The Company’s loss from discontinued operations includes lease-related costs of $15 million ($24 million, net of a $9 million income tax benefit), $12 million ($19 million, net of a $7 million income tax benefit) and $132 million ($214 million, net of an $82 million income tax benefit) in 2010, 2009 and 2008, respectively.

Net loss attributable to noncontrolling interest represents the minority shareholders’ portion of the net loss from our majority owned subsidiary, Generation Health, Inc., which we acquired late in the fourth quarter of 2009. The net loss attributable to noncontrolling interest for the year ended December 31, 2010 was $3 million and was de minimis in 2009.

Net income attributable to CVS Caremark decreased $269 million or 7.3% to $3.4 billion (or $2.49 per diluted share) in 2010. This compares to $3.7 billion (or $2.55 per diluted share) in 2009 and $3.2 billion (or $2.18 per diluted share) in 2008. As previously noted, net income attributable to CVS Caremark in 2010 and 2009 both benefited from previously unrecognized tax benefit.

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
2010:					
Net revenues	$ 47,780	$ 57,345	$ —	$ (8,712)	$ 96,413
Gross profit	3,353	17,039	—	(135)	20,257
Operating profit	2,389	4,537	(626)	(135)	6,165
2009:					
Net revenues	$ 51,065	$ 55,355	$ —	$ (7,691)	$ 98,729
Gross profit	3,835	16,593	—	(48)	20,380
Operating profit	2,866	4,159	(539)	(48)	6,438
2008:					
Net revenues	$ 43,769	$ 48,990	$ —	$ (5,287)	$ 87,472
Gross profit	3,550	14,741	—	(1)	18,290
Operating profit	2,755	3,753	(461)	(1)	6,046

(1) Net revenues of the Pharmacy Services segment include approximately $6.6 billion, $6.9 billion and $6.3 billion of Retail Co-Payments for 2010, 2009 and 2008, respectively. Please 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. As a result, both the Pharmacy Services and the Retail Pharmacy segments include the following results associated with this activity: net revenues of $1,794 million, $692 million and $8 million for the years ended December 31, 2010, 2009 and 2008, respectively; gross profit and operating profit of $135 million, $48 million and $1 million for the years ended December 31, 2010, 2009 and 2008, respectively.

Pharmacy Services Segment

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

In millions	Fiscal Year Ended 2010	2009	2008[4]
Net revenues	$47,780	$51,065	$43,769
Gross profit	3,353	3,835	3,550
Gross profit % of net revenues	7.0%	7.5%	8.1%
Operating expenses	964	969	795
Operating expenses % of net revenues	2.0%	1.9%	1.8%
Operating profit	2,389	2,866	2,755
Operating profit % of net revenues	5.0%	5.6%	6.3%
Net revenues[1]:			
Mail choice[2]	$16,675	$16,711	$14,909
Pharmacy network[3]	30,681	34,004	28,482
Other	424	350	378
Pharmacy claims processed[1]:			
Total	584.8	658.5	633.4
Mail choice[2]	64.2	66.0	60.9
Pharmacy network[3]	520.6	592.5	572.5
Generic dispensing rate[1]:			
Total	71.5%	68.2%	65.1%
Mail choice[2]	61.3%	56.5%	54.4%
Pharmacy network[3]	72.7%	69.3%	66.2%
Mail choice penetration rate	25.8%	23.8%	22.9%

(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 CVS/pharmacy stores.

(4) 2008 includes the results of RxAmerica from the October 20, 2008 acquisition date.

During 2009, the Pharmacy Services segment's results of operations include a full year of RxAmerica results compared to 2008, which includes RxAmerica results from the acquisition date (October 20, 2008) forward.

Net revenues in our Pharmacy Services Segment decreased $3.3 billion, or 6.4%, to $47.8 billion for the year ended December 31, 2010, as compared to the prior year. The decrease in 2010 was primarily due to the termination of a few large client contracts effective January 1, 2010 and the decrease of covered lives under our Medicare Part D program as a result of the 2010 Medicare Part D competitive bidding process, partially offset by new client starts on January 1, 2010. Additionally, the increase in our generic dispensing rate had a negative impact on our revenue in 2010.

Net revenues increased $7.3 billion, or 16.7%, to $51.1 billion for the year ended December 31, 2009, as compared to the prior year. The increase in 2009 was primarily due to the inclusion of RxAmerica which accounted for approximately $3.2 billion of the increase, which included the impact of converting the RxAmerica retail pharmacy network contract to the Caremark contract structure discussed below. Additionally the increase in revenue was attributable to favorable net new business.

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

- The Pharmacy Services segment recognizes revenues for its pharmacy network transactions based on individual contract terms. In accordance with ASC 605, *Revenue Recognition* (formerly Emerging Issues Task Force ("EITF") EITF No. 99-19, "Reporting Revenue Gross as a Principal vs Net as an Agent"), Caremark's contracts are predominantly accounted for using the gross method. Prior to April 1, 2009, RxAmerica's contracts were accounted for using the net method. Effective April 1, 2009, we converted a number of RxAmerica's retail pharmacy network contracts and a large health plan to the Caremark contract structure, which resulted in those contracts being accounted for using the gross method. As a result, net revenues increased by $1.1 billion during 2010 as compared to 2009, and by $2.5 billion during 2009 as compared to 2008.
- Three fewer days in the 2009 fiscal year negatively impacted net revenues by $268 million, compared to 2008.
- During 2010, our mail choice claims processed decreased 2.7% to 64.2 million claims. This decrease was primarily due to the termination of a few large client contracts effective January 1, 2010, partially offset by new client starts on January 1, 2010. During 2009, our mail choice claims processed increased 8.3% to 66.0 million claims. This increase was primarily due to favorable net new business and the significant adoption of the mail choice plan design.
- During 2010 and 2009, our average revenue per mail choice claim increased by 2.6% and 3.5%, compared to 2009 and 2008, respectively. This increase was primarily due to drug cost inflation and claims mix, partially offset by an increase in the percentage of generic prescription drugs dispensed and changes in client pricing.
- During 2010, our mail choice generic dispensing rate increased to 61.3%, compared to our mail choice generic dispensing rate of 56.5% in 2009. During 2009, our mail choice generic dispensing rate increased to 56.5% compared to our mail choice generic dispensing rate of 54.4% in 2008. This continued increase was primarily due to new generic prescription drug introductions and our continuous effort to encourage plan members to use generic prescription drugs when they are available.
- During 2010, our pharmacy network claims processed decreased 12.1% to 520.6 million compared to 592.5 million pharmacy network claims processed in 2009. The decrease in 2010 was primarily due to the termination of a few large client contracts effective January 1, 2010 and the decrease of covered lives under our Medicare Part D program as a result of the 2010 Medicare Part D competitive bidding process. During 2009, our pharmacy network claims processed increased 3.5% or 20.0 million from 572.5 million in 2008. The increase in 2009 was primarily due to an increase in RxAmerica claims of 61.0 million compared with 2008. The RxAmerica increase was partially offset by the reduction in claims due to the termination of two large health plan clients effective January 1, 2009 and having three fewer days in 2009 compared to 2008.
- During 2010, our average revenue per pharmacy network claim processed increased by 2.7%, compared to 2009. The increase was primarily due to the conversion of RxAmerica's pharmacy network contracts from net to gross on April 1, 2009, (ii) a change in the revenue recognition method from net to gross for a large health plan on March 1, 2009 and (iii) higher drug costs, partially offset by an increase in our pharmacy network generic dispensing rate and changes in client pricing.
- During 2009, our average revenue per pharmacy network claim processed increased by 15.4%, compared to 2008. The increase was primarily due to (i) the inclusion of RxAmerica results, whose retail pharmacy network contracts were accounted for using the net revenue recognition method prior to April 1, 2009, as discussed above; (ii) higher drug costs, which normally result in higher claim revenues, and (iii) claims mix; partially offset by client pricing, and changes in the percentage of generic drugs dispensed.
- During 2010, our pharmacy network generic dispensing rate increased to 72.7% compared to our pharmacy network generic dispensing rate of 69.3% in 2009. During 2009, our pharmacy network generic dispensing rate increased to 69.3%, compared to our pharmacy network generic dispensing rate of 66.2% in 2008. These continued increases 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. Additionally, the increase in 2009 as compared to 2008 was partially attributable to the full-year impact of RxAmerica claims which increased our generic dispensing rate by approximately 120 basis points in 2009 compared to 2008. 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.

- During 2010, 2009 and 2008, 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 Accendo (which have been approved by CMS as PDPs), and in 2008, through a joint venture with Universal American Corp. ("UAC"), which sponsored a CMS approved PDP. The Company and UAC dissolved this joint venture at the end of 2008 and divided the responsibility for providing Medicare Part D services to the affected plan members beginning with the 2009 plan year. In December 2010, the Company announced it had entered into an agreement to acquire the Medicare Part D business of UAC for approximately $1.25 billion. The transaction is subject to customary closing conditions, including necessary regulatory approvals, as well as approval by UAC shareholders. The Company currently expects that the transaction will close by the end of the second quarter of 2011. In addition, we assist employer, union and other health plan clients that qualify for the retiree drug subsidy under Medicare Part D by collecting eligibility data from and submitting drug cost data to CMS in order for them to obtain the subsidy.

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 as a percentage of revenues was 7.0%, 7.5% and 8.1% in 2010, 2009 and 2008, respectively.

During 2010, gross profit decreased $482 million, or 12.6%, to $3.4 billion for the year ended December 31, 2010, as compared to the prior year. Gross profit as a percentage of net revenues was 7.0% for the year ended December 31, 2010, compared to 7.5% for the prior year period. The decrease in our gross profit dollars is a result of the loss of "differential" or "spread" resulting from a change in CMS regulations described more fully below, the termination of a few large client contracts effective January 1, 2010 and the decrease of covered lives under our Medicare Part D program, partially offset by new client starts on January 1, 2010. The decrease in gross profit as a percentage of net revenues is primarily due to the loss of "differential" or "spread", pricing compression related to a large client renewal that took effect during the third quarter of 2010, and the change in the revenue recognition method from net to gross associated with the RxAmerica pharmacy network contracts on April 1, 2009 and a large health plan on March 1, 2009. This was partially offset by an increase in our generic dispensing rate for the year ended December 31, 2010, as compared to the prior year.

During 2009, gross profit increased $285 million, or 8.0%, to $3.8 billion for the year ended December 31, 2009, as compared to the prior year. Gross profit as a percentage of net revenues was 7.5% for the year ended December 31, 2009, compared to 8.1% for 2008. The increase in our gross profit dollars is a result of the full year impact of RxAmerica and new client starts on January 1, 2009, partially offset by the loss of two large health plan clients effective January 1, 2009, three fewer days in the 2009 fiscal year compared to 2008 and changes in client pricing. The decrease in gross profit as a percentage of net revenues is primarily due to the change in the revenue recognition method from net to gross associated with the RxAmerica pharmacy network contracts on April 1, 2009 and a large health plan on March 1, 2009 and pricing compression related to new clients and the retention of existing clients. This was partially offset by an increase in our generic dispensing rate for the year ended December 31, 2009, as compared to the prior year period.

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 rates continued to be impacted by our efforts to (i) retain existing clients, (ii) obtain new business and (iii) maintain or improve the purchase discounts we received from manufacturers, wholesalers and retail pharmacies. In particular, competitive pressures in the PBM industry have caused us and other PBMs to share a larger portion of rebates and/or discounts received from pharmaceutical manufacturers. During the 2008 and 2009 selling seasons, the Company renewed a number of existing clients and obtained new clients at lower rates, which resulted in gross profit compression during 2009, and 2010. In addition, market dynamics and regulatory changes have affected our ability to offer plan sponsors pricing terms that include the use of retail network "differential" or "spread", which has impacted our profitability. We expect these trends to continue.
- As discussed previously in this document, 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. Although this change did not affect our gross profit dollars, it did reduce our gross profit rates by approximately 40 basis points in each of 2010 and 2009, and 35 basis points in 2008.
- Our gross profit as a percentage of revenues benefited from the increase in our total generic dispensing rate, which increased to 71.5% and 68.2% in 2010 and 2009, respectively, compared to our generic dispensing rate of 65.1% in 2008. 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. The inclusion of RxAmerica claims increased our total generic dispensing rate by approximately 120 and 20 basis points during 2009 and 2008, respectively.
- Effective January 1, 2010, CMS issued a regulation requiring that any difference 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 (commonly called "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. 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 2010.
- In conjunction with a class action settlement with two entities that publish the Average Wholesale Price ("AWP") of pharmaceuticals (a pricing benchmark widely used in the pharmacy industry), the AWP for many brand-name and some generic prescription drugs were reduced effective September 26, 2009. We reached understandings with most of our commercial third-party payors where we participate as pharmacy providers to adjust reimbursements to account for this change in methodology, but most state Medicaid programs that utilize AWP as a pricing reference did not take action to make similar adjustments.
- Three fewer days in the 2009 fiscal year negatively impacted gross profit by $23 million, compared to 2008.

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, increased to 2.0% of net revenues in 2010, compared to 1.9% and 1.8% in 2009 and 2008, respectively.

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

- During 2010, the decrease in operating expenses of $5 million or approximately 1.0%, to $964 million compared to 2009, is primarily related to lower bad debt expense, and lower operating costs associated with our Medicare Part D program, partially offset by an increase in costs associated with changes designed to streamline our business.
- During 2009, the increase in operating expenses of $174 million, or 21.8%, to $969 million compared to 2008, is primarily related to (i) increased litigation reserves, (ii) the dissolution of our joint venture with UAC at the end of fiscal 2008, the income from which was historically an offset to operating expenses, and (iii) the inclusion of a full year of RxAmerica's operating expenses during 2009.

Retail Pharmacy Segment

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

	Fiscal Year Ended		
In millions	**2010**	**2009**	**2008[1]**
Net revenues	$ 57,345	$ 55,355	$ 48,990
Gross profit	17,039	16,593	14,741
Gross profit % of net revenues	29.7%	30.0%	30.1%
Operating expenses	12,502	12,434	10,988
Operating expenses % of net revenues	21.8%	22.5%	22.4%
Operating profit	4,537	4,159	3,753
Operating profit % of net revenues	7.9%	7.5%	7.7%
Net revenue increase:			
Total	3.6%	13.0%	8.7%
Pharmacy	4.1%	13.1%	8.1%
Front Store	2.6%	12.7%	9.9%
Same store sales increase:[2]			
Total	2.1%	5.0%	4.5%
Pharmacy	2.9%	6.9%	4.8%
Front Store	0.5%	1.2%	3.6%
Generic dispensing rates	73.0%	69.9%	67.4%
Pharmacy % of net revenues	68.0%	67.5%	67.5%
Third party % of pharmacy revenue	97.4%	96.9%	96.1%
Retail prescriptions filled	636.3	616.5	559.0

(1) 2008 includes the results of Longs Drug Stores subsequent to the October 20, 2008 acquisition date.

(2) Same store sales increase includes the Longs Drug Stores beginning in November 2009.

Net revenues in our Retail Pharmacy Segment increased $2.0 billion, or 3.6% to $57.3 billion for the year ended December 31, 2010, as compared to the prior year. This increase was primarily driven by the same store sales increase of 2.1%, and net revenues from new stores, which accounted for approximately 140 basis points of our total net revenue percentage increase for the year ended December 31, 2010. Additionally, we continue to see a positive impact on our net revenues due to the growth of our Maintenance Choice program.

Net revenues increased $6.4 billion, or 13.0% to $55.4 billion for the year ended December 31, 2009, as compared to the prior year. The increase was primarily driven by the same store sales increase of 5.0%, the inclusion of the Longs Acquisition for a full year, as well as net revenue from new stores and a positive impact related 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:

- During 2009, net revenues from the Longs Drug Stores increased net revenues by $3.4 billion, compared to 2008. This increase is primarily due to a full year of net revenues associated with Longs Drug Stores versus a partial fourth quarter in 2008.
- Three fewer days in the 2009 fiscal year negatively impacted net revenues by $403 million, compared to 2008.
- As of December 31, 2010, we operated 7,182 retail stores, compared to 7,025 retail stores on December 31, 2009, and 6,923 retail stores on December 31, 2008. Total net revenues from new stores (excluding acquired stores) contributed approximately 1.4%, 1.6% and 1.5% to our total net revenue percentage increase in 2010, 2009 and 2008, respectively.
- Pharmacy revenue growth continued to benefit from the introduction of a prescription drug benefit under Medicare Part D, 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.
- Pharmacy revenue dollars continue to be negatively impacted in all years by the conversion of brand named drugs to equivalent generic drugs, which typically have a lower selling price. In addition, our pharmacy growth has also been affected by a decline in the number of significant new brand named 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.

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 $446 million, or 2.7%, to $17.0 billion for the year ended December 31, 2010, as compared to the prior year. Gross profit as a percentage of net revenues decreased to 29.7% for the year ended December 31, 2010, compared to 30.0% for the prior year. The decline in gross profit as a percentage of net revenues was driven by declines in the gross profit of our pharmacy sales, partially offset by increases in the gross profit of our front store sales.

Gross profit increased $1.9 billion, or 12.6%, to $16.6 billion for the year ended December 31, 2009, as compared to the prior year. Gross profit as a percentage of net revenues decreased to 30.0% for the year ended December 31, 2009, compared to 30.1% for the prior year.

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

- Three fewer days in the 2009 fiscal year negatively impacted gross profit by $123 million, compared to 2008.
- On average, our gross profit on front-store revenues is higher than our average gross profit on pharmacy revenues. During 2010, our front-store revenues were 32.0% of total revenues, compared to 32.5% in both 2009 and 2008. During 2010, our pharmacy revenues were 68.0% of total revenues, compared to 67.5% in both 2009 and 2008. This shift in sales mix had a negative effect on our overall gross profit for the year ended December 31, 2010.
- During 2010, our front-store gross profit rate was positively impacted by increases in private label and proprietary brand product sales, which normally yield a higher gross profit rate than other front-store products. During 2009, our front-store gross profit rate was negatively impacted by increased sales of promotional related items, which were partially offset by increases in private label and proprietary brand product sales.

- During 2010, 2009 and 2008, our pharmacy gross profit rate continued to benefit from an increase in generic drug revenues, which normally yield a higher gross profit rate than equivalent brand name drug revenues.
- 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 augmented the efforts of third party payors 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 have continued to increase and, thus, have become a larger 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 97.4% of pharmacy revenues in 2010, compared to 96.9% and 96.1% of pharmacy revenues in 2009 and 2008, respectively. We expect this trend to continue.
- The Federal Government's Medicare Part D benefit is increasing prescription utilization. However, it is also decreasing our pharmacy gross profit rates as our higher gross profit business (e.g., cash customers) continued to migrate to Part D coverage during 2010 and 2009.
- The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, "PPACA") made several significant changes to Medicaid rebates and 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 regulations implementing these changes. Therefore, we cannot predict the effect these changes will have on Medicaid reimbursement or their impact on the Company.
- In conjunction with a class action settlement with two entities that publish the AWP of pharmaceuticals, the AWP for many brand-name and some generic prescription drugs were reduced effective September 26, 2009. We reached understandings with virtually all of our commercial third-party payors where we participate as pharmacy providers to adjust reimbursements to account for this change in methodology, but most state Medicaid programs that utilize AWP as a pricing reference did not take action to make similar adjustments. Accordingly, state Medicaid reimbursement was adversely impacted in 2010.

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

Operating expenses increased $68 million, or less than 1%, to $12.5 billion for the year ended December 31, 2010, as compared to the prior year. Operating expenses as a percentage of net revenues decreased to 21.8% for the year ended December 31, 2010, compared to 22.5% for the prior year. The increase in operating expenses in 2010 was the result of higher store operating costs associated with our increased store count, partially offset by the absence of costs incurred related to the integration of the Longs Acquisition.

Operating expenses increased $1.4 billion, or 13.2%, to $12.4 billion for the year ended December 31, 2009, as compared to the prior year. Operating expenses as a percentage of net revenues increased to 22.5% for the year ended December 31, 2009, compared to 22.4% for the prior year. The increase in operating expenses in 2009 was the result of higher store operating costs associated with our increased store count including the Longs Acquisition stores that we owned for a full year in 2009 versus a partial year in 2008, as well as integration costs associated with the Longs Acquisition, partially offset by a positive impact of approximately $92 million due to three fewer days in the 2009 fiscal year as compared to 2008.

Corporate Segment

Operating expenses increased $87 million, or 16.3% and $78 million, or 16.9% during 2010 and 2009, respectively. Operating expenses within the Corporate segment include executive management, corporate relations, legal, compliance, human resources, corporate information technology and finance related costs.

Operating expenses increased during 2010 and 2009 primarily due to higher professional fees, primarily for legal services associated with increased litigation activity, information technology services associated with enterprise initiatives, compensation and benefit costs, and depreciation.

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, strengthen 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 increased to approximately $4.8 billion in 2010. This compares to approximately $4.0 billion and $3.9 billion in 2009 and 2008, respectively. The increase in net cash provided by operating activities during 2010 was primarily due to increases in cash receipts from customers, decreases in inventory purchases, partially offset by cash paid to other suppliers. 2009 includes a full year of net cash provided by operating activities from the Longs Acquisition compared to 2008. 2008 also includes net cash provided by operating activities from the Longs Acquisition from the acquisition date (October 20, 2008) forward.

Net cash used in investing activities increased to approximately $1.6 billion in 2010. This compares to approximately $1.1 billion and $4.6 billion in 2009 and 2008, respectively. The increase in net cash used in investing activities was primarily due to a reduction in the amount of proceeds received from sale-leaseback transactions, partially offset by less cash used for purchases of property and equipment. The decrease in net cash used in investing activities in 2009 was primarily due to a reduction in acquisition activities in 2009 and an increase in sale-leaseback transactions.

Gross capital expenditures totaled approximately $2.0 billion during 2010, compared to approximately $2.5 billion in 2009 and $2.2 billion 2008. The decrease in gross capital expenditures during 2010 was primarily due to the absence of spending which occurred in 2009 related to resets of stores acquired as part of the Longs Acquisition. During 2010, approximately 52.0% of our total capital expenditures were for new store construction, 14.5% were for store expansion and improvements and 33.5% were for technology and other corporate initiatives.

Proceeds from sale-leaseback transactions totaled $507 million in 2010. This compares to $1.6 billion in 2009 and $204 million in 2008. 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. The decrease in 2010 was primarily due to higher transaction volume in 2009 as a result of a deferral of transactions from 2008, due to market conditions. This deferral was the primary reason for the significant increase in 2009 as compared to 2008.

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

	2010[3]	2009[3]	2008[3]
Total stores (beginning of year)	7,074	6,981	6,301
New and acquired stores[1]	179	175	719
Closed stores	(27)	(82)	(39)
Total stores (end of year)	7,226	7,074	6,981
Relocated stores[2]	106	110	129

(1) 2008 includes 529 Longs Drug Stores that were acquired as part of the Longs Acquisition.

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

(3) Excludes specialty mail order facilities.

Net cash used in financing activities was approximately $2.8 billion in 2010, compared to net cash used in financing activities of $3.2 billion in 2009 and net cash provided by financing activities of $929 million in 2008. Net cash used in financing activities during 2010, was primarily due to the repayment of long term debt, of approximately $2.1 billion, $1.5 billion of share repurchases associated with the share repurchase programs described below, partially offset by the proceeds received of $991 million related to the issuance of long-term debt. Net cash used in financing activities during 2009 was primarily due to approximately $2.5 billion of share repurchases associated with the share repurchase programs described below, the net reduction of approximately $2.2 billion of our outstanding commercial paper borrowings, the repayment of $500 million of borrowings outstanding under our bridge credit facility used to finance the Longs Acquisition, and the payment of $439 million of dividends on our common stock. This was partially offset by the net increase in long-term debt of approximately $2.1 billion and proceeds from the exercise of stock options of $250 million. Net cash provided by financing activities during 2008 was primarily due to increased short-term and long-term borrowings used to fund the Longs Acquisition and to retire $353 million of debt assumed as part of the Longs Acquisition.

Share repurchase programs - On June 14, 2010, our Board of Directors authorized a new share repurchase program for up to $2.0 billion of our outstanding common stock (the "2010 Repurchase Program"). The share repurchase authorization, which was effective immediately and expires at the end of 2011, 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. The share repurchase program may be modified, extended or terminated by the Board of Directors at any time. The Company did not make any share repurchases under the 2010 Repurchase Program through December 31, 2010.

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"). In 2009, we repurchased 16.1 million shares of common stock for approximately $500 million pursuant to 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.

On May 7, 2008, our Board of Directors authorized, effective May 21, 2008, a share repurchase program for up to $2.0 billion of our outstanding common stock (the "2008 Repurchase Program"). From May 21, 2008 through December 31, 2008, we repurchased approximately 0.6 million shares of common stock for $23 million under the 2008 Repurchase Program. During the year ended December 31, 2009, we repurchased approximately 57.0 million shares of common stock for approximately $2.0 billion completing the 2008 Repurchase Program.

On May 9, 2007, our Board of Directors authorized a share repurchase program for up to $5.0 billion of our outstanding common stock (the "2007 Repurchase Program"). The 2007 Repurchase Program was completed during 2007 through a $2.5 billion fixed dollar accelerated share repurchase agreement (the "May ASR agreement"), under which final settlement occurred in October 2007 and resulted in the repurchase of

approximately 67.5 million shares of common stock; an open market repurchase program, which concluded in November 2007 and resulted in approximately 5.3 million shares of common stock being repurchased for approximately $212 million; and a $2.3 billion dollar fixed accelerated share repurchase agreement (the "November ASR agreement"), which resulted in an initial 51.6 million shares of common stock being purchased and placed into treasury stock as of December 29, 2007. The final settlement under the November ASR agreement occurred on March 28, 2008 and resulted in us receiving an additional 5.7 million shares of common stock, which were placed into treasury stock as of March 29, 2008.

Recently announced business combination - In December 2010, the Company announced it had entered into an agreement to acquire the Medicare Part D business of UAC for approximately $1.25 billion. The transaction is subject to customary closing conditions, including necessary regulatory approvals, as well as approval by UAC shareholders. The Company currently expects that the transaction will close by the end of the second quarter of 2011. We believe our cash flows from operations, commercial paper program and other available credit will be sufficient to fund this acquisition.

Short-term borrowings - We had $300 million of commercial paper outstanding at a weighted average interest rate of 0.40% as of December 31, 2010. In connection with our commercial paper program, we maintain a $1.4 billion, five-year unsecured back-up credit facility, which expires on May 12, 2011, a $1.3 billion, five-year unsecured back-up credit facility, which expires on March 12, 2012, and a $1.0 billion three-year unsecured back-up credit facility, which expires on May 27, 2013. The credit facilities allow for borrowings at various rates that are dependent, in part, on our public debt rating. There were no borrowings outstanding under the back-up credit facilities. We intend to renew our back-up credit facility which expires in May 2011.

Long-term borrowings - 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 semiannually 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.

On September 8, 2009, we issued $1.5 billion of 6.125% unsecured senior notes due September 15, 2039 (the "September 2009 Notes"). The September 2009 Notes pay interest semi-annually and may be redeemed, in whole or in part, at a defined redemption price plus accrued interest. The net proceeds were used to repay a portion of our outstanding commercial paper borrowings, $650 million of unsecured senior notes and for general corporate purposes.

On March 10, 2009, we issued $1.0 billion of 6.60% unsecured senior notes due March 15, 2019 (the "March 2009 Notes"). The March 2009 Notes pay interest semi-annually and may be redeemed, in whole or in part, at a defined redemption price plus accrued interest. The net proceeds were used to repay the bridge credit facility, a portion of our outstanding commercial paper borrowings and for general corporate purposes.

On July 1, 2009, we issued a $300 million unsecured floating rate senior note due January 30, 2011 (the "2009 Floating Rate Note"). The 2009 Floating Rate Note pays interest quarterly. The net proceeds from the 2009 Floating Rate Note were used for general corporate purposes.

On September 10, 2008, we issued $350 million of floating rate senior notes due September 10, 2010 (the "2008 Notes"). The 2008 Notes pay interest quarterly and may be redeemed at any time, in whole or in part at a defined redemption price plus accrued interest. The net proceeds from the 2008 Notes were used to fund a portion of the Longs Acquisition.

Our backup credit facility, unsecured senior notes and Enhanced Capital Advantaged Preferred Securities (see Note 5 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, 2010 and 2009 we had no freestanding derivatives in place.

Debt Ratings - As of December 31, 2010, our long-term debt was rated "Baa2" by Moody's with a stable outlook and "BBB+" by Standard & Poor's with a negative 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 January 2010, our Board of Directors authorized a 15% increase in our quarterly common stock dividend to $0.0875 per share. This increase equates to an annual dividend rate of $0.35 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 equate to an annual dividend rate of $0.50 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, 2010, the Company guaranteed approximately 70 such store leases (excluding the lease guarantees related to Linens 'n Things), with the maximum remaining lease term extending through 2019. 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 "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, 2010:

	Payments Due by Period				
In millions	**Total**	**2011**	**2012 to 2013**	**2014 to 2015**	**Thereafter**
Operating leases	$26,803	$2,013	$4,088	$3,512	$17,190
Leases from discontinued operations	151	29	46	37	39
Long-term debt	9,605	1,103	3	1,100	7,399
Interest payments on long-term debt[1]	7,280	532	1,008	959	4,781
Other long-term liabilities reflected in our consolidated balance sheet	505	118	83	74	230
Capital lease obligations	340	19	38	39	244
	$44,684	$3,814	$5,266	$5,721	$29,883

(1) Interest payments on long-term debt are calculated on outstanding balances and interest rates in effect on December 31, 2010.

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. The critical accounting policies discussed later in this document are applicable to each of our business segments. 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. We recognize revenues generated from prescription drugs sold by mail service pharmacies when the prescription is shipped. At the time of shipment, we have performed substantially all of our obligations under the client contract and do not experience a significant level of reshipments. We recognize revenues generated from prescription drugs sold by third party pharmacies in our

retail pharmacy network and associated administrative fees are recognized at the point-of-sale, which is when we adjudicate the claim in our 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. Historically, the effect of these adjustments has not been material to our results of operations. 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.

We participate in the Federal Government's Medicare Part D program as a Prescription Drug Plan ("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 the Centers for Medicare and Medicaid Services ("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, 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 2.6%, 3.5% and 1.3% of consolidated net revenues in 2010, 2009 and 2008, 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.

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. We recognize revenue from the sale of prescription drugs at the time the prescription is filled, which is or approximates when the retail customer picks up the prescription. Customer returns are not material. Revenue 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

Our inventory is stated at the lower of cost or market on a first-in, first-out basis using the retail method of accounting to determine cost of sales and inventory in our CVS/pharmacy stores, weighted average cost to determine cost of sales and inventory in our mail service and specialty pharmacies and the cost method of accounting on a first-in, first-out basis to determine 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

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's carrying amount 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 $25.7 billion and $9.8 billion as of December 31, 2010, respectively. We did not record any impairment losses related to goodwill or other intangible assets during 2010, 2009 or 2008. During the third quarter of 2010, 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 Retail Pharmacy reporting unit exceeding its carrying value by a substantial margin and the fair value of our Pharmacy Services reporting unit exceeding its carrying value by approximately 12%. The carrying value of goodwill as of December 31, 2010, in our Retail Pharmacy and Pharmacy Services reporting units was $6.8 billion and $18.9 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 $451 million as of December 31, 2010. This amount is net of $288 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 $29 million as of December 31, 2010.

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 to determine if our self-insurance liability 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 $474 million as of December 31, 2010. 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 $47 million as of December 31, 2010.

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

Recently Adopted Accounting Pronouncements

Effective January 1, 2009, we adopted Accounting Standards Codification ("ASC") 805 *Business Combinations* ("ASC 805") (formerly Statement of Financial Accounting Standard ("SFAS") No. 141 (R), "Business Combinations"). ASC 805 establishes the principles and requirements for how an acquirer recognizes and measures in its financial statements the identifiable assets acquired, the liabilities assumed, any noncontrolling interest in the acquiree and the goodwill acquired. The guidance also establishes disclosure requirements that will enable users to evaluate the nature and financial effects of business combinations. ASC 805 requires that income tax benefits related to business combinations that are not recorded at the date of acquisition are recorded as an income tax benefit in the statement of operations when subsequently recognized. Previously, unrecognized income tax benefits related to business combinations were recorded as an adjustment to the purchase price allocation when recognized. We recognized approximately $34 million and $147 million of previously unrecognized income tax benefits related to business combinations (after considering the federal benefit of state taxes), plus interest, due to the expiration of various statutes of limitation and settlements with tax authorities in 2010 and 2009, respectively. The Company had approximately $10 million and $20 million, in 2010 and 2009, respectively, of unrecognized tax benefits (after considering the federal benefit of state taxes), plus interest, related to business combinations that would have been treated as an adjustment to the purchase price allocation if they would have been recognized under the previous business combination guidance.

In June 2009, the Financial Accounting Standards Board ("FASB") issued guidance that amends ASC 810 *Consolidations* (formerly SFAS No. 167, "Amendments to FASB Interpretation No. 46(R)"). The amendment requires a company to analyze whether its interest in a variable interest entity ("VIE") gives it a controlling financial interest. The determination of whether a company is required to consolidate another entity is based on, among other things, the other entity's purpose and design and a company's ability to direct the activities of the other entity that most significantly impact the other entity's economic performance. Additional disclosures are required to identify a company's involvement with the VIE and any significant changes in risk exposure due to such involvement. The amendment is effective for all new and existing VIEs as of the beginning of the first fiscal year that begins after November 15, 2009. The adoption of this standard did not have a material impact on our consolidated results of operations, financial position or cash flows.

In January 2010, the FASB issued guidance which expanded the required disclosures about fair value measurements. In particular, this guidance requires (i) separate disclosure of the amounts of significant transfers in and out of Level 1 and Level 2 fair value measurements along with the reasons for such transfers, (ii) information about purchases, sales, issuances and settlements to be presented separately in the reconciliation for Level 3 fair value measurements, (iii) expanded fair value measurement disclosures for each class of assets and liabilities and (iv) disclosures about the valuation techniques and inputs used to measure fair value for both recurring and nonrecurring fair value measurements that fall in either Level 2 or Level 3. This guidance is effective for annual reporting periods beginning after December 15, 2009 except for (ii) above which is effective for fiscal years beginning after December 15, 2010. The adoption of this standard did not have a material impact on our consolidated results of operations, financial position or cash flows.

Recently Proposed Accounting Standard Update

In August 2010, the FASB issued a proposed accounting standard update on lease accounting that would require entities to recognize assets and liabilities arising from lease contracts on the balance sheet. The proposed accounting standard update states that lessees and lessors should apply a "right-of-use model" in accounting for all leases. Under the proposed model, lessees would recognize an asset for the right to use the leased asset, and a liability for the obligation to make rental payments over the lease term. The lease term is defined as the longest possible term that is "more likely than not" to occur. The accounting by a lessor would reflect its retained exposure to the risks or benefits of the underlying leased asset. A lessor would recognize an asset representing its right to receive lease payments based on the expected term of the lease. Comments on this exposure draft were due December 15, 2010 and the final standard is expected to be issued sometime in 2011. While we believe that the proposed standard, as currently drafted, will likely have a material impact on our reported financial position and reported results of operations, it will not have a material impact on our liquidity; however, until the proposed standard is finalized, such evaluation cannot be completed.

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 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, 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:

- 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 utilizations trends, the number of covered lives and the financial health of our PBM clients. 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 future sale-leaseback transactions under acceptable terms;
- Our ability to realize the anticipated long-term strategic benefits from our integrated pharmacy services model;
- Our ability to realize the planned benefits associated with the pending acquisition of UAC's Medicare Part D business in accordance with the expected timing;
- The continued efforts of health maintenance organizations, managed care organizations, pharmacy benefit management companies and other third party payors to reduce prescription drug costs and pharmacy reimbursement rates, particularly with respect to generic pharmaceuticals;

- The possibility of client loss and/or the failure to win new client business;
- Risks related to the frequency and rate of the introduction of generic drugs and brand name prescription products;
- The effect on our Pharmacy Services business of a declining margin environment attributable to increased competition in the pharmacy benefit management industry and increased client demands for lower prices, enhanced service offerings and/or higher service levels;
- Risks related to our inability to earn and retain purchase discounts and/or rebates from pharmaceutical manufacturers and to earn and retain retail network "differential" or "spread";
- Risks regarding the impact of the Medicare prescription drug benefit on our business;
- Risks related to the change in industry pricing benchmarks that could adversely affect our financial performance;
- Increased competition from other drugstore chains, supermarkets, discount retailers, membership clubs and Internet companies, as well as changes in consumer preferences or loyalties;
- Risks related to PPACA and other health care reform laws and the regulations promulgated under those laws;
- Litigation, legislative and regulatory risks associated with our business or the retail pharmacy business, retail clinic operations and/or pharmacy benefit management industry generally;
- The risks relating to changes in laws and regulations, including changes in accounting standards and taxation requirements (including tax rate changes, new tax laws and revised tax law interpretations);
- The risks relating to adverse developments in the health care or pharmaceutical industry generally, including, but not limited to, developments in any investigation related to the pharmaceutical industry that may be conducted by any governmental authority; and
- Other risks and uncertainties detailed from time to time in our filings with the Securities and Exchange Commission.

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 material adverse effects 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, 2010.

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, 2010.

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 report is based upon an audit conducted in accordance with the standards of the Public Company Accounting Oversight Board (United States).

February 18, 2011

Report of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders
CVS Caremark Corporation

We have audited CVS Caremark Corporation's internal control over financial reporting as of December 31, 2010, 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, 2010, 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, 2010 and 2009 and the related consolidated statements of income, shareholders' equity and cash flows for each of the three years in the period ended December 31, 2010 of CVS Caremark Corporation and our report dated February 18, 2011 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Boston, Massachusetts
February 18, 2011

Consolidated Statements of Income

In millions, except per share amounts	Year Ended December 31, 2010	2009	2008
Net revenues	$96,413	$98,729	$87,472
Cost of revenues	76,156	78,349	69,182
Gross profit	20,257	20,380	18,290
Operating expenses	14,092	13,942	12,244
Operating profit	6,165	6,438	6,046
Interest expense, net	536	525	509
Income before income tax provision	5,629	5,913	5,537
Income tax provision	2,190	2,205	2,193
Income from continuing operations	3,439	3,708	3,344
Loss from discontinued operations, net of income tax benefit	(15)	(12)	(132)
Net income	3,424	3,696	3,212
Net loss attributable to noncontrolling interest	3	—	—
Preference dividends, net of income tax benefit	—	—	(14)
Net income attributable to CVS Caremark	$ 3,427	$ 3,696	$ 3,198
Basic earnings per common share:			
Income from continuing operations attributable to CVS Caremark	$ 2.52	$ 2.59	$ 2.32
Loss from discontinued operations attributable to CVS Caremark	(0.01)	(0.01)	(0.09)
Net income attributable to CVS Caremark	$ 2.51	$ 2.58	$ 2.23
Weighted average common shares outstanding	1,367	1,434	1,434
Diluted earnings per common share:			
Income from continuing operations attributable to CVS Caremark	$ 2.50	$ 2.56	$ 2.27
Loss from discontinued operations attributable to CVS Caremark	(0.01)	(0.01)	(0.09)
Net income attributable to CVS Caremark	$ 2.49	$ 2.55	$ 2.18
Weighted average common shares outstanding	1,377	1,450	1,469
Dividends declared per common share	$ 0.350	$ 0.305	$ 0.258

See accompanying notes to consolidated financial statements.

Consolidated Balance Sheets

In millions, except per share amounts	December 31, 2010	December 31, 2009
Assets:		
Cash and cash equivalents	$ 1,427	$ 1,086
Short-term investments	4	5
Accounts receivable, net	4,925	5,457
Inventories	10,695	10,343
Deferred income taxes	511	506
Other current assets	144	140
Total current assets	17,706	17,537
Property and equipment, net	8,322	7,923
Goodwill	25,669	25,680
Intangible assets, net	9,784	10,127
Other assets	688	374
Total assets	$62,169	$61,641
Liabilities:		
Accounts payable	$ 4,026	$ 3,560
Claims and discounts payable	2,569	3,075
Accrued expenses	3,070	3,246
Short-term debt	300	315
Current portion of long-term debt	1,105	2,104
Total current liabilities	11,070	12,300
Long-term debt	8,652	8,756
Deferred income taxes	3,655	3,678
Other long-term liabilities	1,058	1,102
Commitments and contingencies (Note 12)		
Redeemable noncontrolling interest	34	37
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; 1,624 shares issued and 1,363 shares outstanding at December 31, 2010 and 1,612 shares issued and 1,391 shares outstanding at December 31, 2009	16	16
Treasury stock, at cost: 259 shares at December 31, 2010 and 219 shares at December 31, 2009	(9,030)	(7,610)
Shares held in trust: 2 shares at December 31, 2010 and 2009	(56)	(56)
Capital surplus	27,610	27,198
Retained earnings	19,303	16,355
Accumulated other comprehensive loss	(143)	(135)
Total shareholders' equity	37,700	35,768
Total liabilities and shareholders' equity	$62,169	$61,641

See accompanying notes to consolidated financial statements.

Consolidated Statements of Cash Flows

In millions	Year Ended December 31, 2010	2009	2008
Cash flows from operating activities:			
Cash receipts from revenues	$ 94,503	$ 93,568	$ 82,250
Cash paid for inventory and prescriptions dispensed by retail network pharmacies	(73,143)	(73,536)	(64,131)
Cash paid to other suppliers and employees	(13,778)	(13,121)	(11,832)
Interest and dividends received	4	5	20
Interest paid	(583)	(542)	(574)
Income taxes paid	(2,224)	(2,339)	(1,786)
Net cash provided by operating activities	4,779	4,035	3,947
Cash flows from investing activities:			
Additions to property and equipment	(2,005)	(2,548)	(2,180)
Proceeds from sale-leaseback transactions	507	1,562	204
Acquisitions (net of cash acquired) and other investments	(177)	(101)	(2,651)
Purchase of short-term investments	—	(5)	—
Proceeds from sale or maturity of short-term investments	1	—	28
Proceeds from sale or disposal of assets	34	23	19
Net cash used in investing activities	(1,640)	(1,069)	(4,580)
Cash flows from financing activities:			
Increase (decrease) in short-term debt	(15)	(2,729)	959
Repayment of debt assumed in acquisition	—	—	(353)
Issuance of long-term debt	991	2,800	350
Repayments of long-term debt	(2,103)	(653)	(2)
Dividends paid	(479)	(439)	(383)
Derivative settlements	(5)	(3)	—
Proceeds from exercise of stock options	285	250	328
Excess tax benefits from stock-based compensation	28	19	53
Repurchase of common stock	(1,500)	(2,477)	(23)
Net cash provided by (used in) financing activities	(2,798)	(3,232)	929
Net increase (decrease) in cash and cash equivalents	341	(266)	296
Cash and cash equivalents at beginning of year	1,086	1,352	1,056
Cash and cash equivalents at end of year	$ 1,427	$ 1,086	$ 1,352
Reconciliation of net income to net cash provided by operating activities:			
Net income	$ 3,424	$ 3,696	$ 3,212
Adjustments required to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	1,469	1,389	1,274
Stock-based compensation	150	165	92
Deferred income taxes and other noncash items	30	48	(3)
Change in operating assets and liabilities, net of effects from acquisitions:			
Accounts receivable, net	532	(86)	(291)
Inventories	(352)	(1,199)	(488)
Other current assets	(4)	48	12
Other assets	(210)	(2)	19
Accounts payable	(40)	4	(64)
Accrued expenses	(176)	(66)	183
Other long-term liabilities	(44)	38	1
Net cash provided by operating activities	$ 4,779	$ 4,035	$ 3,947

See accompanying notes to consolidated financial statements.

Consolidated Statements of Shareholders' Equity

In millions	Shares — Year Ended December 31, 2010	Shares — 2009	Shares — 2008	Dollars — Year Ended December 31, 2010	Dollars — 2009	Dollars — 2008
Preference stock:						
Beginning of year	—	4	4	$ —	$ 191	$ 202
Conversion to common stock	—	(4)	—	—	(191)	(11)
End of year	—	—	4	$ —	$ —	$ 191
Common stock:						
Beginning of year	1,612	1,603	1,590	$ 16	$ 16	$ 16
Stock options exercised and stock awards	12	9	13	—	—	—
End of year	1,624	1,612	1,603	$ 16	$ 16	$ 16
Treasury stock:						
Beginning of year	(219)	(165)	(154)	$ (7,610)	$ (5,812)	$ (5,620)
Purchase of treasury shares	(42)	(73)	(7)	(1,500)	(2,477)	(33)
Conversion of preference stock	—	17	1	—	583	35
Transfer from shares held in trust	—	—	(7)	—	—	(272)
Employee stock purchase plan issuances	2	2	2	80	96	78
End of year	(259)	(219)	(165)	$ (9,030)	$ (7,610)	$ (5,812)
Guaranteed ESOP obligation:						
Beginning of year				$ —	$ —	$ (44)
Reduction of guaranteed ESOP obligation				—	—	44
End of year				$ —	$ —	$ —
Shares held in trust:						
Beginning of year	(2)	(2)	(9)	$ (56)	$ (56)	$ (301)
Transfer to treasury stock	—	—	7	—	—	245
End of year	(2)	(2)	(2)	$ (56)	$ (56)	$ (56)
Capital surplus:						
Beginning of year				$27,198	$27,280	$26,832
Conversion of shares held in trust to treasury stock				—	—	27
Stock option activity and stock awards				384	291	392
Tax benefit on stock options and stock awards				28	19	53
Conversion of preference stock				—	(392)	(24)
End of year				$27,610	$27,198	$27,280

See accompanying notes to consolidated financial statements.

Consolidated Statements of Shareholders' Equity

In millions	Shares Year Ended December 31, 2010	2009	2008	Dollars Year Ended December 31, 2010	2009	2008
Retained earnings:						
Beginning of year				$16,355	$13,098	$10,287
Net income (excludes net loss attributable to noncontrolling interest of $3 in 2010)				3,427	3,696	3,212
Common stock dividends				(479)	(439)	(370)
Preference stock dividends				—	—	(14)
Tax benefit on preference stock dividends				—	—	1
Adoption of ASC 715-60 (formerly EITF 06-04 and 06-10)				—	—	(18)
End of year				$19,303	$16,355	$13,098
Accumulated other comprehensive loss:						
Beginning of year				$ (135)	$ (143)	$ (50)
Net cash flow hedges, net of income tax				(1)	1	3
Pension liability adjustment, net of income tax				(7)	7	(96)
End of year				$ (143)	$ (135)	$ (143)
Total shareholders' equity				$37,700	$35,768	$34,574
Comprehensive income:						
Net income				$ 3,424	$ 3,696	$ 3,212
Net cash flow hedges, net of income tax				(1)	1	3
Pension liability adjustment, net of income tax				(7)	7	(96)
Comprehensive income				3,416	3,704	3,119
Comprehensive loss attributable to noncontrolling interest				3	—	—
Comprehensive income attributable to CVS Caremark				$ 3,419	$ 3,704	$ 3,119

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") comprise the largest pharmacy health care provider (based on revenues and prescriptions filled) in the United States.

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 65,000 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's 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 28 conditions, through Alere, L.L.C. and the Company's Accordant® health management offering.

In addition, through the Company's SilverScript Insurance Company ("SilverScript") and Accendo Insurance Company ("Accendo") subsidiaries, the PSS is a national provider of drug benefits to eligible beneficiaries under the Federal Government's Medicare Part D program. The PSS acquired Accendo in the Longs Acquisition (defined later in Note 2), and, effective January 1, 2009, Accendo replaced RxAmerica® as the Medicare-approved prescription drug plan for the RxAmerica Medicare Part D drug benefit plans.

The pharmacy services business 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, CarePlus™ , RxAmerica®, Accordant® and TheraCom® names. As of December 31, 2010, the Pharmacy Services segment operated 44 retail specialty pharmacy stores, 18 specialty mail order pharmacies and four mail service pharmacies located in 25 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, 2010, the retail pharmacy business included 7,182 retail drugstores (of which 7,123 operated a pharmacy) located in 41 states the District of Columbia and Puerto Rico operating primarily under the

CVS/ pharmacy name, the online retail website, CVS.com and 560 retail health care clinics operating under the MinuteClinic name (of which 550 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.

Reclassifications - Certain reclassifications have been made to the 2009 and 2008 consolidated financial statements to conform to the current year presentation.

Fiscal Year Change - On December 23, 2008, the Board of Directors of the Company approved a change in the Company's fiscal year end from the Saturday nearest December 31 of each year to December 31 of each year to better reflect the Company's position in the health care, rather than the retail, industry. The fiscal year change was effective beginning with the fourth quarter of fiscal 2008.

Following is a summary of the imp

commercial paper, time deposits, as well as other debt securities that are classified as cash and 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, 2010 and 2009.

Fair value of financial instruments - As of December 31, 2010, the Company's financial instruments include cash and cash equivalents, 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 long-term debt was $9.8 billion and $10.5 billion, respectively, as of December 31, 2010. The fair value of long-term debt was estimated based on rates currently offered to the Company for debt with similar terms and maturities. The Company had outstanding letters of credit, which guaranteed foreign trade purchases, with a fair value of $6 million and $9 million as of December 31, 2010 and 2009, respectively. There were no outstanding investments in derivative financial instruments as of December 31, 2010 and 2009.

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:

	Fiscal Year Ended December 31,		
In millions	**2010**	**2009**	**2008**
Opening balance	$ 224	$ 189	$108
Additions charged to bad debt expense	73	135	121
Write-offs charged to allowance	(115)	(100)	(40)
Ending balance	$ 182	$ 224	$189

Inventories - Inventories are stated at the lower of cost or market on a first-in, first-out basis using the retail method of accounting to determine cost of sales and inventory in the Company's CVS/pharmacy stores, weighted average cost to determine cost of sales and inventory in the Company's mail service and specialty pharmacies and the cost method of accounting on a first-in, first-out basis to determine inventory in the Company's distribution centers. 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	2010	2009
Land	$ 1,247	$ 1,076
Building and improvements	2,265	2,020
Fixtures and equipment	7,148	6,322
Leasehold improvements	2,866	2,673
Software	757	853
	14,283	12,944
Accumulated depreciation and amortization	(5,961)	(5,021)
	$ 8,322	$ 7,923

The gross amount of property and equipment under capital leases was $191 million as of December 31, 2010 and 2009, respectively.

Goodwill - Goodwill and other indefinite-lived assets are not amortized, but are subject to impairment reviews annually, or more frequently if necessary. See Note 3 for additional information on goodwill.

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 3 for additional information about intangible assets.

Impairment of long-lived assets - The Company groups and evaluates fixed and finite-lived intangible assets, excluding goodwill, for impairment at the lowest level at which individual cash flows can be identified. When evaluating assets for potential impairment, 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 - The Company has an approximately 60% ownership interest in Generation Health, Inc. ("Generation Health") and consolidates Generation Health in its consolidated financial statements. The noncontrolling shareholders of Generation Health hold 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 $27 million and a maximum of $159 million, depending on certain financial metrics of Generation Health in 2014. Since the noncontrolling shareholders of Generation Health have a redemption feature as a result of the put right, the Company has classified the redeemable noncontrolling interest in Generation Health in the mezzanine section of the consolidated balance sheet outside of shareholders' equity. The Company initially recorded the redeemable noncontrolling interest at a fair value of $37 million on the date of acquisition. At the end of each reporting period, if the estimated accreted redemption value exceeds the carrying value of the noncontrolling interest, the difference is recorded as a reduction of retained earnings. Any such reductions in retained earnings would also reduce income attributable to CVS Caremark in the Company's earnings per share calculations.

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

In millions	2010	2009
Beginning balance	$ 37	$—
Acquisition of Generation Health	—	37
Net loss attributable to noncontrolling interest	(3)	—
Ending balance	$ 34	$ 37

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 revenues from prescription drugs sold by its mail service pharmacies and under retail pharmacy network contracts where the PSS is the principal using the gross method at the contract prices negotiated with its clients. Net revenue from the PSS includes: (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" later in this document), (ii) the price paid to the PSS ("Mail Co-Payments") or a third party pharmacy in the PSS' retail pharmacy network ("Retail Co-Payments") by individuals included in its clients' benefit plans and (iii) administrative fees for retail pharmacy network contracts where the PSS is not the principal as discussed below.

The PSS recognizes revenue 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 Company has established the following revenue recognition policies 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 Company has performed substantially all of its obligations under its client contracts and does not experience a significant level of reshipments.
- Revenues generated from prescription drugs sold by third party pharmacies in the PSS' retail pharmacy network and associated administrative fees are recognized at the PSS' point-of-sale, which is when the claim is adjudicated by the PSS' 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' 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' 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 physician 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, the PSS records revenues using the net method.

Drug Discounts - The PSS deducts from its revenues any rebates, inclusive of discounts and fees, earned by its clients. The PSS pays rebates to its clients in accordance with the terms of its 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 the PSS' 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"). The PSS' 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 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 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, the PSS' net revenues include co-payments, 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 the PSS' net revenues. The Company assumes no risk for these amounts, which represented 2.6%, 3.5% and 1.3% of consolidated net revenues in 2010, 2009 and 2008, 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.

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). See Note 7 for additional information about Medicare Part D.

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, which is or approximates when the retail customer picks up the prescription. Customer returns are not material. Revenue generated from the performance of services in the RPS' health care clinics is recognized at the time the services are performed. See Note 13 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 13 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 $368 million and $424 million in 2010 and 2009, respectively.

Advertising costs - Advertising costs are expensed when the related advertising takes place. Advertising costs, net of vendor funding (included in operating expenses), were $234 million, $317 million and $324 million in 2010, 2009 and 2008, respectively.

Interest expense, net - Interest expense, net of capitalized interest, was $539 million, $530 million and $530 million, and interest income was $3 million, $5 million and $21 million in 2010, 2009 and 2008, respectively. Capitalized interest totaled $47 million, $39 million and $28 million in 2010, 2009 and 2008, respectively.

Shares held in trust - The Company maintains grantor trusts, which held approximately 2 million shares of its common stock at December 31, 2010 and 2009. 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 $217 million pre-tax ($132 million after-tax) as of December 31, 2010 and $203 million pre-tax ($125 million after-tax) as of December 31, 2009. The net impact on cash flow hedges totaled $18 million pre-tax ($11 million after-tax) and $15 million pre-tax ($10 million after-tax) as of December 31, 2010 and 2009, respectively.

Stock-based compensation - 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 3 to 5 years) using the straight-line method. Stock-based compensation costs are included in selling, general and administrative expenses.

Income taxes - The Company provides for federal and state income taxes currently payable, as well as for those deferred because of timing differences between reported income and expenses for financial statement purposes versus tax purposes. Federal and state tax credits are recorded as a reduction of income taxes. Deferred 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 purposes. Deferred 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 tax rates is recognized as income or expense in the period of the change.

Loss from discontinued operations - In connection with certain business dispositions completed between 1991 and 1997, the Company continues to guarantee store lease obligations for a number of former subsidiaries, including Linens 'n Things. On May 2, 2008, Linens Holding Co. and certain affiliates, which operate Linens 'n Things, filed voluntary petitions under Chapter 11 of the United States Bankruptcy Code in the United States Bankruptcy Court for the District of Delaware. The Company's loss from discontinued operations includes lease related costs of $15 million ($24 million, net of a $9 million income tax benefit), $12 million ($19 million, net of a $7 million income tax benefit) and $132 million ($214 million, net of an $82 million income tax benefit) for the years ended December 31, 2010, 2009 and 2008, respectively, associated with the Linens 'n Things lease guarantee's.

Earnings per common share - Basic earnings per common share is computed by dividing: (i) net earnings, after deducting the after-tax Employee Stock Ownership Plan ("ESOP") preference dividends, by (ii) the weighted average number of common shares outstanding during the year (the "Basic Shares").

When computing diluted earnings per common share for fiscal year 2008, the Company assumed that the ESOP preference stock was converted into common stock and all dilutive stock awards were exercised. After the assumed ESOP preference stock conversion, the ESOP Trust would hold common stock rather than ESOP preference stock and would receive common stock dividends ($0.25800 per share in 2008) rather than ESOP preference stock dividends ($3.90 per share). Since the ESOP Trust used the dividends it received to service its debt, the Company had to increase its contribution to the ESOP Trust to compensate it for the lower dividends. This additional contribution reduced the Company's net earnings, which in turn, reduced the amounts that would be accrued under the Company's incentive compensation plans.

Diluted earnings per common share is computed by dividing: (i) net income attributable to CVS Caremark, after accounting for the difference between the dividends on the ESOP preference stock and common stock and after making adjustments for the incentive compensation plans, by (ii) Basic Shares plus the additional shares that would be issued assuming that all dilutive stock awards are exercised and the ESOP preference stock is converted into common stock. Options to purchase 34.3 million, 37.7 million and 20.9 million shares of common stock were outstanding as of December 31, 2010, 2009 and 2008, 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. See Note 8 for additional information about the ESOP.

Recently Adopted Accounting Pronouncements

Effective January 1, 2009, the Company adopted Accounting Standards Codification ("ASC") 805 *Business Combinations* ("ASC 805") (formerly Statement of Financial Accounting Standard ("SFAS") No. 141 (R), "Business Combinations"). ASC 805 establishes the principles and requirements for how an acquirer recognizes and measures in its financial statements the identifiable assets acquired, the liabilities assumed, any noncontrolling interest in the acquiree and the goodwill acquired. The guidance also establishes disclosure requirements that will enable users to evaluate the nature and financial effects of business combinations. ASC 805 requires that income tax benefits related to business combinations that are not recorded at the date of acquisition are recorded as an income tax benefit in the statement of income when subsequently recognized. Previously, unrecognized income tax benefits related to business combinations were recorded as an adjustment to the purchase price allocation when recognized. The Company recognized approximately $34 million and $147 million of previously unrecognized income tax benefits related to business combinations (after considering the federal benefit of state taxes), plus interest, due to the expiration of various statutes of limitation and settlements with tax authorities in 2010 and 2009, respectively. As of December 31, 2010 and 2009, the Company had approximately $10 million and $20 million, respectively, of unrecognized tax benefits (after considering the federal benefit of state taxes), plus interest, related to business combinations that would have been treated as an adjustment to the purchase price allocation if they would have been recognized under the previous business combination guidance.

In June 2009, the Financial Accounting Standards Board ("FASB") issued guidance that amends ASC 810 *Consolidations* (formerly SFAS No. 167, "Amendments to FASB Interpretation No. 46(R)"). The amendment requires a company to analyze whether its interest in a variable interest entity ("VIE") gives it a controlling financial interest. The determination of whether a company is required to consolidate another entity is based on, among other things, the other entity's purpose and design and a company's ability to direct the activities of the other entity that most significantly impact the other entity's economic performance. Additional disclosures are required to identify a company's involvement with the VIE and any significant changes in risk exposure due to such involvement. The amendment is effective for all new and existing VIEs as of the beginning of the first fiscal year that begins after November 15, 2009. The adoption of this standard did not have a material impact on the Company's consolidated results of operations, financial position or cash flows.

In January 2010, the FASB issued guidance which expanded the required disclosures about fair value measurements. In particular, this guidance requires (i) separate disclosure of the amounts of significant transfers in and out of Level 1 and Level 2 fair value measurements along with the reasons for such transfers, (ii) information about purchases, sales, issuances and settlements to be presented separately in the reconciliation for Level 3 fair value measurements, (iii) expanded fair value measurement disclosures for each class of assets and liabilities and (iv) disclosures about the valuation techniques and inputs used to measure fair value for both recurring and nonrecurring fair value measurements that fall in either Level 2 or Level 3. This guidance is effective for annual reporting periods beginning after December 15, 2009 except for (ii) above which is effective for fiscal years beginning after December 15, 2010. The adoption of this standard did not have a material impact on the Company's consolidated results of operations, financial position or cash flows.

Recently Proposed Accounting Standard Update

In August 2010, the FASB issued a proposed accounting standard update on lease accounting that would require entities to recognize assets and liabilities arising from lease contracts on the balance sheet. The proposed accounting standard update states that lessees and lessors should apply a "right-of-use model" in accounting for all leases. Under the proposed model, lessees would recognize an asset for the right to use the leased asset, and a liability for the obligation to make rental payments over the lease term. The lease term is defined as the longest possible term that is "more likely than not" to occur. The accounting by a lessor would reflect its retained exposure to the risks or benefits of the underlying leased asset. A lessor would recognize an asset representing its right to receive lease payments based on the expected term of the lease. Comments on this exposure draft were due December 15, 2010 and the final standard is expected to be issued sometime in 2011. While the Company believes that the proposed standard, as currently drafted, will likely have a material impact on its reported financial position and reported results of operations, it will not have a material impact on its liquidity; however, until the proposed standard is finalized, such evaluation cannot be completed.

2 Business Combinations

Effective October 20, 2008, the Company acquired Longs Drug Stores Corporation for approximately $2.6 billion (the "Longs Acquisition"). The fair value of the assets acquired and liabilities assumed were $4.4 billion and $1.8 billion, respectively. The Longs Acquisition included 529 retail drug stores, RxAmerica, LLC, which provides pharmacy benefit management services and Medicare Part D benefits and other related assets. The Company's results of operations and cash flows include the Longs Acquisition beginning October 20, 2008.

Effective December 30, 2009, the Company acquired an approximately 60% interest in Generation Health, a genetic benefit management company for approximately $34 million in cash and issued certain put rights to the remaining noncontrolling shareholders. The put rights allow the noncontrolling shareholders to require the Company to buy their shares for cash in the future, depending on certain financial metrics of Generation Health. The fair value of the redeemable noncontrolling interest including put rights on the date of acquisition was approximately $37 million which was determined using inputs classified as Level 3 in the fair value hierarchy. The Company's results of operations and cash flows include the Generation Health acquisition beginning December 30, 2009.

3 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. As the Company utilizes internal financial projections for the determination of future cash flows, the fair value methodology is considered to use inputs classified as Level 3 in the fair value hierarchy. 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 2010, 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 $25.7 billion as of December 31, 2010 and 2009.

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. As this method of estimating fair value utilizes internal financial projections for determination of future cash flows, the fair value methodology is considered to use inputs classified as Level 3 in the fair value hierarchy. 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 2010, 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 indefinitely-lived assets was $6.4 billion as of December 31, 2010 and 2009. Intangible assets with finite useful lives are amortized over their estimated useful lives.

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 13.3 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 of the Company's favorable leases and other intangible assets are 16.3 years. Amortization expense for intangible assets totaled $427 million, $430 million and $405 million in 2010, 2009 and 2008, respectively. The anticipated annual amortization expense for these intangible assets is $419 million in 2011, $399 million in 2012, $376 million in 2013, $344 million in 2014 and $316 million in 2015.

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

	2010			2009		
In millions	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount
Trademarks (indefinitely-lived)	$ 6,398	$ —	$ 6,398	$ 6,398	$ —	$ 6,398
Customer contracts and relationships and covenants not to compete	4,903	(1,982)	2,921	4,828	(1,604)	3,224
Favorable leases and other	762	(297)	465	756	(251)	505
	$12,063	$ (2,279)	$ 9,784	$11,982	$(1,855)	$10,127

4 Share Repurchase Programs

On June 14, 2010, the Company's Board of Directors authorized a new share repurchase program for up to $2.0 billion of outstanding common stock (the "2010 Repurchase Program"). The share repurchase authorization, which was effective immediately and expires at the end of 2011, 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 share repurchase program may be modified, extended or terminated by the Board of Directors at any time. The Company did not make any share repurchases under the 2010 Repurchase Program through December 31, 2010.

On November 4, 2009, the Company's Board of Directors authorized, effective immediately, a share repurchase program for up to $2.0 billion of its outstanding common stock (the "2009 Repurchase Program"). From November 4, 2009 through December 31, 2009, the Company repurchased 16.1 million shares of common stock for approximately $500 million under the 2009 Repurchase Program. During the year ended December 31, 2010, the Company repurchased 42.4 million shares of common stock for approximately $1.5 billion completing the 2009 Repurchase Program.

On May 7, 2008, the Company's Board of Directors authorized, effective May 21, 2008, a share repurchase program for up to $2.0 billion of its outstanding common stock (the "2008 Repurchase Program"). From May 21, 2008 through December 31, 2008, the Company repurchased approximately 0.6 million shares of common stock for $23 million under the 2008 Repurchase Program. During the year ended December 31, 2009, the Company repurchased approximately 57.0 million shares of common stock for approximately $2.0 billion completing the 2008 Repurchase Program.

On May 9, 2007, the Company's Board of Directors authorized a share repurchase program for up to $5.0 billion of its outstanding common stock. The share repurchase program was completed during 2007 through a $2.5 billion fixed dollar accelerated share repurchase agreement (the "May ASR agreement"), under which final settlement occurred in October 2007 and resulted in the repurchase of approximately 67.5 million shares of common stock; an open market repurchase program, which concluded in November 2007 and resulted in approximately 5.3 million shares of common stock being repurchased for approximately $212 million; and a $2.3 billion dollar fixed accelerated share repurchase agreement (the "November ASR agreement"), which resulted in an initial 51.6 million shares of common stock being purchased and placed into treasury stock as of December 29, 2007. The final settlement under the November ASR agreement occurred on March 28, 2008 and resulted in the Company receiving an additional 5.7 million shares of common stock, which were placed into treasury stock as of March 29, 2008.

5 Borrowing and Credit Agreements

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

In millions	2010	2009
Commercial paper	$ 300	$ 315
Floating rate notes due 2010	—	350
Floating rate notes due 2010	—	1,750
5.75% senior notes due 2011	800	800
Floating rate note due 2011[1]	300	300
4.875% senior notes due 2014	550	550
3.250% senior notes due 2015	550	—
6.125% senior notes due 2016	700	700
5.75% senior notes due 2017	1,750	1,750
6.60% senior notes due 2019	1,000	1,000
4.75% senior notes due 2020	450	—
6.25% senior notes due 2027	1,000	1,000
6.125% note due 2039	1,500	1,500
6.302% Enhanced Capital Advantage Preferred Securities[2]	1,000	1,000
Mortgage notes payable	6	6
Capital lease obligations	151	154
	10,057	11,175
Less:		
Short-term debt (commercial paper)	(300)	(315)
Current portion of long-term debt	(1,105)	(2,104)
	$ 8,652	$ 8,756

(1) As of December 31, 2010, the interest rate for the Company's floating rate note due in 2011 was 1.663%.

(2) The Enhanced Capital Advantaged Preferred Securities ("ECAPS") are due June 1, 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.

In connection with its commercial paper program, the Company maintains a $1.4 billion, five-year unsecured back-up credit facility, which expires on May 12, 2011, a $1.3 billion, five-year unsecured back-up credit facility, which expires on March 12, 2012, and a $1.0 billion, three-year unsecured back-up credit facility which expires on May 27, 2013. The credit facilities allow for borrowings at various rates depending on the Company's public debt ratings and require the Company to pay a quarterly facility fee of 0.1%, regardless of usage. As of December 31, 2010, the Company had no outstanding borrowings against the back-up credit facilities. The weighted average interest rate for short-term debt was 0.40% as of December 31, 2010 and 0.31% as of December 31, 2009.

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 semiannually 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.

On March 10, 2009, the Company issued $1.0 billion of 6.60% unsecured senior notes due March 15, 2019 (the "March 2009 Notes"). The March 2009 Notes pay interest semi-annually and may be redeemed, in whole or in part, at a defined redemption price plus accrued interest. The net proceeds were used to repay the bridge credit facility, a portion of the Company's outstanding commercial paper borrowings and for general corporate purposes.

On July 1, 2009, the Company issued a $300 million unsecured floating rate senior note due January 30, 2011 (the "2009 Floating Rate Note"). The 2009 Floating Rate Note pays interest quarterly. The net proceeds from the 2009 Floating Rate Note were used for general corporate purposes.

On September 8, 2009, the Company issued $1.5 billion of 6.125% unsecured senior notes due September 15, 2039 (the "September 2009 Notes"). The September 2009 Notes pay interest semi-annually and may be redeemed, in whole or in part, at a defined redemption price plus accrued interest. The net proceeds were used to repay a portion of the Company's outstanding commercial paper borrowings, $650 million of unsecured senior notes and for general corporate purposes.

On September 10, 2008, the Company issued $350 million of floating rate senior notes due September 10, 2010 (the "2008 Notes"). The 2008 Notes pay interest quarterly. The net proceeds from the 2008 Notes were used to fund a portion of the Longs Acquisition.

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, 2010 are $1.1 billion in 2011, $2 million in 2012, $1 million in 2013, $550 million in 2014, and $550 million in 2015.

6 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, 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, 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	2010	2009	2008
Minimum rentals	$2,001	$1,857	$1,691
Contingent rentals	53	61	58
	2,054	1,918	1,749
Less: sublease income	(19)	(19)	(25)
	$2,035	$1,899	$1,724

The following table is a summary of the future minimum lease payments under capital and operating leases as of December 31, 2010:

In millions	Capital Leases	Operating Leases[1]
2011	$ 19	$ 2,013
2012	19	2,096
2013	19	1,992
2014	19	1,788
2015	20	1,724
Thereafter	244	17,190
Total future lease payments	340	$26,803
Less: imputed interest	(189)	
Present value of capital lease obligations	$ 151	

(1) Future operating lease payments have not been reduced by minimum sublease rentals of $266 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 $507 million in 2010, $1.6 billion in 2009 and $204 million in 2008.

7 Medicare Part D

The Company offers Medicare Part D benefits through SilverScript and Accendo, 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 Accendo are licensed domestic insurance companies under the applicable laws and regulations. Pursuant to these laws and regulations, SilverScript and Accendo 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 2011; (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.

8 Employee Stock Ownership Plan

The Company sponsored a defined contribution Employee Stock Ownership Plan (the "ESOP") that covered full-time employees with at least one year of service.

In 1989, the ESOP Trust issued and sold $358 million of 20-year, 8.52% notes, which were due and retired on December 31, 2008 (the "ESOP Notes"). The proceeds from the ESOP Notes were used to purchase 7 million shares of Series One ESOP Convertible Preference Stock (the "ESOP Preference Stock") from the Company. Since the ESOP Notes were guaranteed by the Company, the outstanding balance was reflected as long-term debt, and a corresponding guaranteed ESOP obligation was reflected in shareholders' equity in the consolidated balance sheet.

Each share of ESOP Preference Stock had a guaranteed minimum liquidation value of $53.45, was convertible into 4.628 shares of common stock and was entitled to receive an annual dividend of $3.90 per share.

The ESOP Trust used the dividends received and contributions from the Company to repay the ESOP Notes. As the ESOP Notes were repaid, ESOP Preference Stock was allocated to plan participants based on (i) the ratio of each year's debt service payment to total current and future debt service payments multiplied by (ii) the number of unallocated shares of ESOP Preference Stock in the plan.

As of December 31, 2010 and 2009, no shares of ESOP Preference Stock were outstanding and allocated to plan participants. On January 30, 2009, pursuant to the Company's Amended and Restated Certificate of Incorporation (the "Charter"), the Company informed the trustee of the ESOP Trust of its intent to redeem for cash all of the outstanding shares of ESOP Preference Stock on February 24, 2009 (the "Redemption Date"). Under the Charter, at any time prior to the Redemption Date, the trustee had the right to convert the ESOP Preference Stock into shares of the Company's Common Stock. The conversion rate at the time of the notice was 4.628 shares of Common Stock for each share of ESOP Preference Stock. The trustee exercised its right of conversion on February 23, 2009, and all outstanding shares of ESOP Preference Stock were converted into Common Stock.

Annual ESOP expense recognized is equal to (i) the interest incurred on the ESOP Notes plus (ii) the higher of (a) the principal repayments or (b) the cost of the shares allocated, less (iii) the dividends paid. Similarly, the guaranteed ESOP obligation is reduced by the higher of (i) the principal payments or (ii) the cost of shares allocated.

9 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) and Employee Stock Ownership Plan absent certain restrictions and limitations under the Internal Revenue Code. The Company's contributions under the above defined contribution plans totaled $186 million, $173 million and $117 million in 2010, 2009 and 2008, 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, 2010 and 2009, the Company's postretirement medical plans have an accumulated postretirement benefit obligation of $17 million. Net periodic benefit costs related to these postretirement medical plans were approximately $1 million for 2010, 2009 and 2008, 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 one of the nonqualified plans.

As of December 31, 2010, the Company's pension plans had a projected benefit obligation of $659 million and plan assets of $426 million. As of December 31, 2009, the Company's pension plans had a projected benefit obligation of $612 million and plan assets of $372 million. Net periodic pension costs related to these pension plans were $36 million, $16 million and $9 million in 2010, 2009 and 2008, respectively. The net periodic pension costs for 2010 includes settlements of $12 million.

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 5.5% in 2010 and 6.0% in 2009. 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 2010 and 8.5% in 2009 and 2008.

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 were 60% equity and 40% fixed income. As the result of a detailed asset liability study performed during 2009, the Company revised the pension plan target asset allocation to 50% equity and 50% fixed income with the transition to the new targets to begin during 2010.

As of December 31, 2010, the Company's qualified defined benefit pension plan assets consisted of 57% equity, 42% fixed income, and 1% money market securities of which 71% were classified as Level 1 and 29% as Level 2 in the fair value hierarchy. The Company's qualified defined benefit pension plan assets as of December 31, 2009 consisted of 64% equity, 35% fixed income, and 1% money market securities of which 67% were classified as Level 1 and 33% as Level 2 in the fair value hierarchy.

The Company contributed $65 million, $50 million and $8 million to the pension plans during 2010, 2009 and 2008, respectively. The Company plans to make approximately $90 million in contributions to the pension plans during 2011.

Pursuant to various labor agreements, the Company is also required to make contributions to certain union-administered pension and health and welfare plans that totaled $58 million, $57 million and $49 million in 2010, 2009 and 2008, respectively.

10 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 1999 Employee Stock Purchase Plan (the "1999 ESPP") and the 2007 Employee Stock Purchase Plan (the "2007 ESPP" and collectively, the "ESPP") totaled $127 million, $136 million and $106 million for 2010, 2009 and 2008, respectively. The recognized tax benefit was $42 million, $45 million and $33 million for 2010, 2009 and 2008, respectively. Compensation expense related to restricted stock awards totaled $23 million, $29 million and $19 million for 2010, 2009 and 2008, respectively.

The 1999 ESPP provides for the purchase of up to 15 million shares of common stock. As a result of the 1999 ESPP not having sufficient shares available for the program to continue beyond 2007, the Board of Directors adopted, and shareholders approved, the 2007 ESPP. 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 and provides for the purchase of up to 15 million shares of common stock. During 2010, 3 million shares of common stock were purchased, under the provisions of the 2007 ESPP, at an average price of $25.97 per share. As of December 31, 2010, 15 million and 7 million shares of common stock have been issued under the 1999 ESPP and 2007 ESPP, respectively.

The fair value of stock-based compensation associated with the Company's 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:

	2010	2009	2008
Dividend yield[(1)]	0.57%	0.50%	0.32%
Expected volatility[(2)]	32.58%	48.89%	25.22%
Risk-free interest rate[(3)]	0.21%	0.31%	2.75%
Expected life *(in years)*[(4)]	0.5	0.5	0.5
Weighted-average grant date fair value	$ 7.31	$ 8.51	$ 8.73

(1) The dividend yield is calculated based on semi-annual dividends paid and the fair market value of the Company's stocga(a) or.1(u)k.5(51)6y0.0004 Tc0.0317 Tw[(Ex)-4.9(8(n).)6aaran.

In 2007, the Board of Directors adopted and shareholders approved the 2007 Incentive Plan. The terms of the 2007 Incentive Plan 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. The payment of such annual incentive and long-term performance awards will be in cash, stock, other awards or other property, in the discretion of the Management Planning and Development Committee of the Company's Board of Directors, with any payment in stock to be pursuant to the Company's 1997 Incentive Compensation Plan (the "1997 ICP").

The Company's 1997 ICP provided for the granting of up to 153 million shares of common stock in the form of stock options and other awards to selected officers, employees and directors of the Company. The 1997 ICP allowed for up to 7 million restricted shares to be issued. 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.

In May 2010, the Company's Board of Directors adopted and the shareholders approved the 2010 Incentive Compensation Plan (the "2010 ICP"). 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. As of December 31, 2010, there were 72 million shares available for future grants under the 2010 ICP.

The Company granted 1,095,000, 1,284,000 and 1,274,000 restricted stock units with a weighted average fair value of $35.25, $27.77 and $40.70 in 2010, 2009 and 2008, respectively. As of December 31, 2010, there was $34 million of total unrecognized compensation costs related to the restricted stock units that are expected to vest. These costs are expected to be recognized over a weighted-average period of 1.80 years.

The following table is a summary of the restricted unit and restricted share award activity under the ICPs as of December 31:

	2010		2009	
Units in thousands	**Units**	**Weighted Average Grant Date Fair Value**	**Units**	**Weighted Average Grant Date Fair Value**
Nonvested at beginning of year	3,347	$ 32.90	4,052	$31.88
Granted	1,095	35.25	1,284	27.77
Vested	(1,618)	32.35	(1,807)	26.49
Forfeited	(136)	33.58	(182)	37.55
Nonvested at end of year	2,688	$ 34.16	3,347	$32.90

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 during and subsequent to fiscal 2004 generally become exercisable over a three-year period from the grant date and expire seven years after the date of grant.

Excess tax benefits of $28 million, $19 million and $53 million were included in financing activities in the accompanying consolidated statements of cash flow during 2010, 2009 and 2008, respectively. Cash received

from stock options exercised, which includes the ESPP, totaled $285 million, $250 million and $328 million during 2010, 2009 and 2008, respectively. The total intrinsic value of options exercised was $118 million, $104 million and $250 million in 2010, 2009 and 2008, 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:

	2010	2009	2008
Dividend yield[1]	1.00%	1.07%	0.60%
Expected volatility[2]	33.15%	31.34%	22.98%
Risk-free interest rate[3]	1.85%	1.65%	2.28%
Expected life *(in years)*[4]	4.3	4.3	4.3
Weighted-average grant date fair value	$ 9.49	$ 7.20	$ 8.53

(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, 2010, unrecognized compensation expense related to unvested options totaled $156 million, which the Company expects to be recognized over a weighted-average period of 1.66 years. After considering anticipated forfeitures, the Company expects approximately 28 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, 2010:

Shares in thousands	**Shares**	**Weighted Average Exercise Price**	**Weighted Average Remaining Contractual Term**	**Aggregate Intrinsic Value**
Outstanding at December 31, 2009	66,269	$ 29.14	4.39	345,068,000
Granted	14,168	$ 35.16	—	—
Exercised	(10,463)	$ 21.71	—	—
Forfeited	(2,332)	$ 33.50	—	—
Expired	(1,625)	$ 31.83	—	—
Outstanding at December 31, 2010	66,017	$ 31.39	4.16	$313,163,000
Exercisable at December 31, 2010	36,789	$ 29.64	3.03	$235,843,000

11 Income Taxes

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

In millions	2010	2009	2008
Current: Federal	$1,894	$1,766	$1,680
State	345	397	365
	2,239	2,163	2,045
Deferred: Federal	(44)	38	133
State	(5)	4	15
	(49)	42	148
Total	$2,190	$2,205	$2,193

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

	2010	2009	2008
Statutory income tax rate	35.0%	35.0%	35.0%
State income taxes, net of federal tax benefit	4.1	4.5	4.1
Other	0.6	0.6	0.5
Recognition of previously unrecognized tax benefits	(0.8)	(2.8)	—
Effective income tax rate	38.9%	37.3%	39.6%

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	2010	2009
Deferred tax assets:		
Lease and rents	$ 325	$ 334
Inventory	69	55
Employee benefits	261	250
Allowance for bad debt	96	130
Retirement benefits	99	94
Net operating losses	6	8
Other	307	287
Total deferred tax assets	1,163	1,158
Deferred tax liabilities:		
Depreciation and amortization	(4,307)	(4,330)
Net deferred tax liabilities	$ (3,144)	$ (3,172)

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

In millions	2010	2009
Deferred tax assets—current	$ 511	$ 506
Deferred tax liabilities—noncurrent	(3,655)	(3,678)
Net deferred tax liabilities	$(3,144)	$(3,172)

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	2010	2009
Beginning balance	$ 61	$ 257
Additions based on tax positions related to the current year	1	1
Additions based on tax positions related to prior years	2	12
Reductions for tax positions of prior years	(10)	(6)
Expiration of statutes of limitation	(16)	(155)
Settlements	(3)	(48)
Ending balance	$ 35	$ 61

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 2002. 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 $24 million.

During 2010, the Internal Revenue Service (the "IRS") completed an examination of the Company's 2009 consolidated U.S. income tax return 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. Additionally, in 2010, the Company resolved a protest it had previously filed with the IRS Appeals Office regarding various assessments made in connection with the IRS examinations of Caremark's consolidated U.S. income tax returns for 2006 and for its short tax year ended March 22, 2007.

The IRS is currently examining the Company's 2010 consolidated U.S. income tax year pursuant to the CAP program. 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, 2010, 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 year ended December 31, 2010, the Company recognized interest of approximately $3 million. The Company had approximately $11 million accrued for interest and penalties as of December 31, 2010.

There are no material reserves established at December 31, 2010 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 $23 million, after considering the federal benefit of state income taxes.

12 Commitments and Contingencies

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, 2010, the Company guaranteed approximately 70 such store leases (excluding the lease guarantees related to Linens 'n Things, which are discussed in Note 1 previously in this document), with the maximum remaining lease term extending through 2019. 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.

Caremark (the term "Caremark" being used herein to generally refer to any one or more of the 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. The parties previously filed cross motions for partial summary judgment, and in August 2008, the court granted several of Caremark's motions and denied the motions filed by the plaintiffs. The court's rulings are favorable to Caremark and substantially limit the ability of the plaintiffs to assert false claims act allegations or statutory or common law theories of recovery based on Caremark's processing of Medicaid and other government reimbursement requests. The court's rulings are on appeal before the United States Court of Appeals for the Fifth Circuit. 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 our processing of Texas Medicaid claims on behalf of PBM clients. The claims and issues raised in this lawsuit are related to the claims and issues pending in the federal qui tam lawsuit described above.

In December 2007, the Company received a document subpoena from the Office of Inspector General, United States Department of Health and Human Services ("OIG"), requesting information relating to the processing of Medicaid and other government agency claims on a different adjudication platform of Caremark. 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 this OIG subpoena, and other information related to the processing of Medicaid claims. The 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 of Caremark's adjudication platforms. The Company has been producing documents on a rolling basis in

response to the requests for information contained in the OIG subpoena and in these two civil investigative demands. The Company cannot predict with certainty the timing or outcome of any review of such information.

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. The attorneys and law firms named as defendants in McArthur's intervention pleadings have been dismissed from the case, and discovery on class certification and adequacy issues is underway.

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. 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 was transferred to Illinois federal court, and the Bellevue case 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 the 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. 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.

Beginning in November 2008, the Company received and responded to several subpoenas from the Drug Enforcement Administration ("DEA"), Los Angeles Field Division, requesting sales data and other information regarding the Company's distribution of products containing pseudoephedrine ("PSE") at certain retail pharmacies and from one California distribution center. In September 2009, the United States Attorney's Office for the Central District of California ("USAO") and the DEA commenced discussions with the Company regarding whether, in late 2007 and 2008, the Company distributed PSE in violation of the Controlled Substances Act. In addition, the DEA issued an order to show cause against certain retail pharmacies and the Company's La Habra, California distribution center which could have resulted in administrative action against the Company's DEA registrations for these facilities. On October 13, 2010, the Company entered into a comprehensive resolution of this matter, resulting in the payment of $75 million in civil penalties for violations of the Controlled Substances Act and $2.6 million in criminal forfeiture relating to the sales of products containing PSE. The resolution included the entry of a non-prosecution agreement and civil settlement agreement with the USAO, the U.S. Attorney's Office for the District of Nevada and the U.S. Department of Justice, as well as a memorandum of agreement with the DEA that dismisses the above-referenced orders to show cause and contains certain ongoing compliance requirements for the Company.

In August 2009, the Company was notified by the Federal Trade Commission (the "FTC") that it is conducting a non-public investigation under the Federal Trade Commission Act into certain of the Company's business practices. In March 2010, the Company learned that various State Attorneys General offices and certain other government agencies are conducting a multi-state investigation of the Company regarding issues similar to those being investigated by the FTC. At this time, 24 states, the District of Columbia, and the County of Los Angeles are known to be participating in this multi-state investigation. The Company has been cooperating in these investigations, and continues to provide documents and other information as requested. The Company is not able to predict with certainty the timing or outcome of these investigations. However, it remains confident that its business practices and service offerings (which are designed to reduce health care costs and expand consumer choice) are being conducted in compliance with the antitrust laws.

In March 2009, the Company received a subpoena from the OIG requesting information concerning the Medicare Part D prescription drug plans of RxAmerica, the PBM subsidiary of Longs Drug Stores Corporation which was acquired by the Company in October 2008. The Company continues to respond to this request for information and has been producing responsive documents on a rolling basis. The Company cannot predict with certainty the timing or outcome of any review by the government of such information.

Since March 2009, the Company has been named in a series of putative collective and class action lawsuits filed in federal courts around the country, purportedly on behalf of current and former assistant store managers working in the Company's stores at various locations outside California. The lawsuits allege that the Company failed to pay overtime to assistant store managers as required under the Fair Labor Standards Act ("FLSA") and under certain state statutes. The lawsuits also seek other relief, including liquidated damages, punitive damages, attorneys' fees, costs and injunctive relief arising out of the state and federal claims for overtime pay. Notice has been issued to over 13,000 current and former assistant store managers offering them the opportunity to "opt in" to certain of the FLSA collective actions and over 1,900 have elected to participate in these lawsuits. At this time, the Company is not able to predict the outcome of these cases, or the possible monetary exposure associated with the lawsuits. The Company's position, however, is that the lawsuits are without merit and that the cases should not be certified as class or collective actions. The Company is vigorously defending these claims, but can not predict with certainty the timing or outcome of this matter.

In January 2010, the Company received a subpoena from the OIG in connection with an investigation of possible false or otherwise improper claims for payment under the Medicare and Medicaid programs. The subpoena requests retail pharmacy claims data for "dual eligible" customers (i.e., customers with both Medicaid and private insurance coverage), information concerning the Company's retail pharmacy claims processing systems, copies of pharmacy payor contracts and other documents and records. The Company has provided documents and other information in response to the subpoena and continues to engage in discussions with the government about the subject matter of the subpoena. The Company cannot predict with certainty the timing or outcome of any review by the government of such information.

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 continues to respond to this request for information and has been producing responsive documents on a rolling basis. We cannot predict with certainty the timing or outcome of any reviews by the government of such information.

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 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. The Company believes these lawsuits are without merit and the Company plans to defend them vigorously.

The Company cannot predict the ultimate outcome of the legal matters disclosed above. Management does not believe, however, that the outcome of any of these legal matters will have a material adverse effect on the Company's operating results or financial condition.

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 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, as they may relate to our business or the pharmacy services or retail industry; (iii) pending or future federal or state governmental investigations of our business or the pharmacy services or retail industry; (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 or retail industry.

13 Segment Reporting

The Company currently has three 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
2010:					
Net revenues	$ 47,780	$ 57,345	$ —	$(8,712)	$ 96,413
Gross profit	3,353	17,039	—	(135)	20,257
Operating profit	2,389	4,537	(626)	(135)	6,165
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
2009:					
Net revenues	$ 51,065	$ 55,355	$ —	$(7,691)	$ 98,729
Gross profit	3,835	16,593	—	(48)	20,380
Operating profit	2,866	4,159	(539)	(48)	6,438
Depreciation and amortization	377	965	47	—	1,389
Total assets	33,082	28,302	774	(517)	61,641
Goodwill	18,879	6,801	—	—	25,680
Additions to property and equipment	218	2,183	147	—	2,548
2008:					
Net revenues	$ 43,769	$ 48,990	$ —	$(5,287)	$ 87,472
Gross profit	3,550	14,741	—	(1)	18,290
Operating profit	2,755	3,753	(461)	(1)	6,046
Depreciation and amortization	357	881	36	—	1,274
Total assets	32,850	27,406	1,053	(349)	60,960
Goodwill	18,818	6,676	—	—	25,494
Additions to property and equipment	228	1,840	112	—	2,180

(1) Net revenues of the Pharmacy Services segment include approximately $6.6 billion, $6.9 billion and $6.3 billion of Retail co-payments for the fiscal years ended December 31, 2010, 2009 and 2008, 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. As a result, both the Pharmacy Services and the Retail Pharmacy segments include the following results associated with this activity: net revenues of $1,794 million, $692 million and $8 million for the years ended December 31, 2010, 2009 and 2008, respectively; gross profit and operating profit of $135 million, $48 million and $1 million for the years ended December 31, 2010, 2009 and 2008, respectively.

14 Earnings Per Common Share

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

In millions, except per share amounts	2010	2009	2008
Numerator for earnings per common share calculation:			
Income from continuing operations	$ 3,439	$ 3,708	$ 3,344
Net loss attributable to noncontrolling interest	3	—	—
Preference dividends, net of income tax benefit	—	—	(14)
Income from continuing operations attributable to CVS Caremark, basic	3,442	3,708	3,330
Loss from discontinued operations, net of income tax benefit	(15)	(12)	(132)
Net income attributable to CVS Caremark, basic	$ 3,427	$ 3,696	$ 3,198
Income from continuing operations	$ 3,439	$ 3,708	$ 3,344
Net loss attributable to noncontrolling interest	3	—	—
Dilutive earnings adjustments	—	—	(3)
Income from continuing operations attributable to CVS Caremark, diluted	3,442	3,708	3,341
Loss from discontinued operations attributable to CVS Caremark, net of income tax benefit	(15)	(12)	(132)
Net income attributable to CVS Caremark, diluted	$ 3,427	$ 3,696	$ 3,209
Denominator for earnings per common share calculation:			
Weighted average common shares, basic	1,367	1,434	1,434
Preference stock	—	1	17
Stock options	8	10	13
Restricted stock units	2	5	5
Weighted average common shares, diluted	1,377	1,450	1,469
Basic earnings per common share:			
Income from continuing operations attributable to CVS Caremark	$ 2.52	$ 2.59	$ 2.32
Loss from discontinued operations attributable to CVS Caremark	(0.01)	(0.01)	(0.09)
Net income attributable to CVS Caremark	$ 2.51	$ 2.58	$ 2.23
Diluted earnings per common share:			
Income from continuing operations attributable to CVS Caremark	$ 2.50	$ 2.56	$ 2.27
Loss from discontinued operations attributable to CVS Caremark	(0.01)	(0.01)	(0.09)
Net income attributable to CVS Caremark	$ 2.49	$ 2.55	$ 2.18

15 Quarterly Financial Information (Unaudited)

In millions, except per share amounts	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Fiscal Year
2010:					
Net revenues	$ 23,760	$ 24,007	$ 23,875	$ 24,771	$ 96,413
Gross profit	4,746	5,020	5,024	5,467	20,257
Operating profit	1,410	1,501	1,484	1,770	6,165
Income from continuing operations	772	822	819	1,026	3,439
Loss from discontinued operations, net of income tax benefit	(2)	(1)	(11)	(1)	(15)
Net income	770	821	808	1,025	3,424
Net loss attributable to noncontrolling interest	1	—	1	1	3
Net income attributable to CVS Caremark	$ 771	$ 821	$ 809	1,026	3,427
Basic earnings per common share:					
Income from continuing operations attributable to CVS Caremark	$ 0.56	$ 0.61	$ 0.60	$ 0.75	$ 2.52
Loss from discontinued operations attributable to CVS Caremark	—	—	(0.01)	—	(0.01)
Net income attributable to CVS Caremark	$ 0.56	$ 0.61	$ 0.59	$ 0.75	$ 2.51
Diluted Earnings per common share:					
Income from continuing operations attributable to CVS Caremark	$ 0.55	$ 0.60	$ 0.60	$ 0.75	$ 2.50
Loss from discontinued operations attributable to CVS Caremark	—	—	(0.01)	—	(0.01)
Net income attributable to CVS Caremark	$ 0.55	$ 0.60	$ 0.59	$ 0.75	$ 2.49
Dividends per common share	$ 0.08750	$0.08750	$ 0.08750	$ 0.08750	$0.35000
Stock price: (New York Stock Exchange)					
High	$ 37.32	$ 37.82	$ 32.09	$ 35.46	$ 37.82
Low	$ 30.36	$ 29.22	$ 26.84	$ 29.45	$ 26.84
2009:					
Net revenues	$ 23,394	$ 24,871	$ 24,642	$ 25,822	$ 98,729
Gross profit	4,748	5,052	5,012	5,568	20,380
Operating profit	1,377	1,600	1,566	1,895	6,438
Income from continuing operations	744	890	1,023	1,051	3,708
Loss from discontinued operations, net of income tax benefit	(5)	(3)	(2)	(2)	(12)
Net income attributable to CVS Caremark	739	887	1,021	1,049	3,696
Basic earnings per common share:					
Income from continuing operations attributable to CVS Caremark	$ 0.51	$ 0.61	$ 0.72	$ 0.75	$ 2.59
Loss from discontinued operations attributable to CVS Caremark	—	—	(0.01)	—	(0.01)
Net income attributable to CVS Caremark	$ 0.51	$ 0.61	$ 0.71	$ 0.75	$ 2.58
Diluted Earnings per common share:					
Income from continuing operations attributable to CVS Caremark	$ 0.51	$ 0.60	$ 0.71	$ 0.74	$ 2.56
Loss from discontinued operations attributable to CVS Caremark	(0.01)	—	—	—	(0.01)
Net income attributable to CVS Caremark	$ 0.50	$ 0.60	$ 0.71	$ 0.74	$ 2.55
Dividends per common share	$ 0.07625	$0.07625	$ 0.07625	$ 0.07625	$0.30500
Stock price: (New York Stock Exchange)					
High	$ 30.47	$ 34.22	$ 37.75	$ 38.27	$ 38.27
Low	$ 23.74	$ 27.08	$ 30.58	$ 27.38	$ 23.74

Five-Year Financial Summary

In millions, except per share amounts	2010[1]	2009[1]	2008[1]	2007[1][2]	2006[1]
Statement of operations data:					
Net revenues	$ 96,413	$ 98,729	$ 87,472	$ 76,330	$ 43,821
Gross profit	20,257	20,380	18,290	16,108	11,742
Operating expenses[3]	14,092	13,942	12,244	11,314	9,300
Operating profit[4]	6,165	6,438	6,046	4,794	2,442
Interest expense, net	536	525	509	435	216
Income tax provision[5]	2,190	2,205	2,193	1,722	857
Income from continuing operations	3,439	3,708	3,344	2,637	1,369
Loss from discontinued operations, net of tax benefit[6]	(15)	(12)	(132)	—	—
Net income	3,424	3,696	3,212	2,637	1,369
Net loss attributable to noncontrolling interest[7]	3	—	—	—	—
Preference dividends, net of income tax benefit	—	—	(14)	(14)	(14)
Net income attributable to CVS Caremark	$ 3,427	$ 3,696	$ 3,198	$ 2,623	$ 1,355
Per common share data:					
Basic earnings per common share:					
Income from continuing operations attributable to CVS Caremark	$ 2.52	$ 2.59	$ 2.32	$ 1.97	$ 1.65
Loss from discontinued operations attributable to CVS Caremark	(0.01)	(0.01)	(0.09)	—	—
Net income attributable to CVS Caremark	$ 2.51	$ 2.58	$ 2.23	$ 1.97	$ 1.65
Diluted earnings per common share:					
Income from continuing operations attributable to CVS Caremark	$ 2.50	$ 2.56	$ 2.27	$ 1.92	$ 1.60
Loss from discontinued operations attributable to CVS Caremark	(0.01)	(0.01)	(0.09)	—	—
Net income attributable to CVS Caremark	$ 2.49	$ 2.55	$ 2.18	$ 1.92	$ 1.60
Cash dividends per common share	$0.35000	$0.30500	$0.25800	$0.22875	$0.15500
Balance sheet and other data:					
Total assets	$ 62,169	$ 61,641	$ 60,960	$ 54,722	$ 20,574
Long-term debt	$ 8,652	$ 8,756	$ 8,057	$ 8,350	$ 2,870
Total shareholders' equity	$ 37,700	$ 35,768	$ 34,574	$ 31,322	$ 9,918
Number of stores (at end of year)	7,226	7,074	6,981	6,301	6,205

(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 fiscal 2010 and 2009 include 365 days; fiscal 2008 includes 368 days, and fiscal 2007 and 2006 include 364 days.

(2) Effective March 22, 2007, Caremark Rx, Inc. was merged into a newly formed subsidiary of CVS Corporation, with Caremark Rx, L.L.C., continuing as the surviving entity (the "Caremark Merger"). Following the Caremark Merger, the name of the Company was changed to "CVS Caremark Corporation." By virtue of the Caremark Merger, each issued and outstanding share of Caremark common stock, par value $0.001 per share, was converted into the right to receive 1.67 shares of CVS Caremark's common stock, par value $0.01 per share. Cash was paid in lieu of fractional shares.

(3) In 2006, the Company adopted the SEC Staff Accounting Bulletin ("SAB") No. 108, "Considering the Effects of Prior Year Misstatements when Qualifying Misstatements in Current Year Financial Statements." The adoption of this SAB resulted in a $40 million pre-tax ($25 million after-tax) decrease in operating expenses for 2006.

(4) Operating profit includes the pre-tax effect of the charge discussed in Note (3) above.

(5) Income tax provision includes the effect of the following: (i) in 2010, the recognition of $47 million of previously unrecognized tax benefits, including interest, realting 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, and (iii) in 2006, a $11 million reversal of previously recorded tax reserves through the tax provision principally based on resolving certain state tax matters.

(6) In connection with certain business dispositions completed between 1991 and 1997, the Company continues to guarantee store lease obligations for a number of former subsidiaries, including Linens 'n Things. On May 2, 2008, Linens Holding Co. and certain affiliates, which operate Linens 'n Things, filed voluntary petitions under Chapter 11 of the United States Bankruptcy Code in the United States Bankruptcy Court for the District of Delaware. The loss from discontinued operations includes lease-related costs of $15 million ($24 million, net of a $9 million income tax benefit), $12 million ($19 million, net of an $7 million income tax benefit) and $132 million ($214 million, net of an $82 million income tax benefit) in 2010, 2009 and 2008, respectively, which the Company believes is likely to be required to satisfy its obligations associated with its Linens 'n Things lease guarantees.

Report of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders
CVS Caremark Corporation

We have audited the accompanying consolidated balance sheets of CVS Caremark Corporation as of December 31, 2010 and 2009, and the related consolidated statements of income, shareholders' equity, and cash flows for each of the three years in the period ended December 31, 2010. 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 auditing 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, 2010 and 2009, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2010, in conformity with U.S. generally accepted accounting principles.

As discussed in Note 1 to the consolidated financial statements, effective January 1, 2009 CVS Caremark Corporation adopted ASC 805, *Business Combinations* (formerly Statement of Financial Accounting Standards No. 141(R), *Business Combinations*).

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, 2010, 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 18, 2011 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Boston, Massachusetts
February 18, 2011

Exhibit 21

SUBSIDIARIES OF THE REGISTRANT

As of December 31, 2010, CVS Caremark Corporation had the following significant subsidiaries:

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

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(1) CVS Pharmacy, Inc. is the immediate parent of approximately 37 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 Registration Statements (Nos. 333-49407, 333-34927, 333-28043, 333-91253, 333-63664, 333-139470, 333-141481, and 333-167746 on Form S-8 and 333-165672 on Form S-3) of CVS Caremark Corporation and in the related Prospectuses of our reports dated February 18, 2011, with respect to the consolidated financial statements of CVS Caremark Corporation, and the effectiveness of internal control over financial reporting of CVS Caremark Corporation, included in this Annual Report (Form 10-K) for the year ended December 31, 2010 and to the reference to our firm under the heading “Selected Financial Data”, included therein, filed with the Securities and Exchange Commission.

/s/ Ernst & Young LLP

Boston, Massachusetts
February 18, 2011

Exhibit 31.1

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

I, Thomas M. Ryan, Chairman of the Board 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 18, 2011

By: /s/ THOMAS M. RYAN

Thomas M. Ryan
Chairman of the Board 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.

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, 2010 (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, Thomas M. Ryan, Chairman of the Board 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 18, 2011

/s/ THOMAS M. RYAN

Thomas M. Ryan
Chairman of the Board 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, 2010 (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 18, 2011

/S/ DAVID M. DENTON

David M. Denton
Executive Vice President and Chief Financial Officer